

7553

## CERTIFICATE OF DEATH

Reg. Dist. No. 117530

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u>		c. LENGTH OF STAY IN 1b <u>38 Yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1724 Hall Ave.</u>		d. STREET ADDRESS <u>1724 Hall Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Stephen J. Arata, Sr.</u>		4. DATE OF DEATH <u>July 14 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 30, 1893</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gas Electric</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Arata</u>		14. MOTHER'S MAIDEN NAME <u>Mary Raveio</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-05-4277</u>	
17. INFORMANT <u>Stephen J. Arata, Jr.</u>		Address <u>1724 Hall Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Liver</u> 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>15 mos</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>March</u> , 19 <u>58</u> , to <u>July 14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 13</u> , 19 <u>59</u> , and that death occurred at <u>2:00 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. Earl Pass</u> M.D.		DATE SIGNED <u>7-14-59</u>	
PHYSICIAN'S NAME (Type) <u>E. EARL PASS M.D.</u>		<u>Balto 24 Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/18/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem</u>	22d. LOCATION (City, town, or county) <u>Baltimore Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ambrose, Inc.</u>		ADDRESS <u>1328 Sulphur Sp Rd.</u>	
24a. REC'D BY REGISTRAR <u>JUL 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1901

101891

DECEASED

NAME

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Registrar

Signature of Physician

Signature of Coroner

Signature of Burial Officer

Signature of Minister

Signature of Undertaker

Signature of Witness

Signature of Family

Signature of Other

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7557

## CERTIFICATE OF DEATH

Reg. Dist. No.

07531

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTO.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTO. SUBURBAN</b>				c. LENGTH OF STAY IN 1b <b>2 YRS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4146 WILKENS AVE.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>JACOB BAYRLE</b>				4. DATE OF DEATH Month Day Year <b>JULY 28 1959</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG 9, 1915</b>	9. AGE (In years last birthday) <b>43</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WATCH MAN (RET.)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>SHIPS</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>GEORGE BAYRLE</b>				14. MOTHER'S MAIDEN NAME <b>GERTRUDE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>214-26-6885</b>		17. INFORMANT <b>MRS. MILRED MASKELL -AME</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage, internal</b> 572.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Dysentery of intestines small and large</b> DUE TO (c) <b>mal and large</b>							INTERVAL BETWEEN ONSET AND DEATH <b>15 minutes</b> <b>5 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>3-8</b> , 19 <b>59</b> , to <b>7-28</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7-28</b> , 19 <b>59</b> , and that death occurred at <b>10 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1227 Waver Blvd Baltimore</b> DATE SIGNED <b>7/29/59</b>							
ACTUAL SIGNATURE <b>John P. Urlock Jr.</b> M.D.				PHYSICIAN'S NAME (Type) <b>JOHN P. URLOCK JR.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>AUG 1, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>HOLY CROSS Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Ritchie Hwy A-A Co, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Cowardson Hollins St.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 30 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kinn</b>	

CERTIFICATE OF DEATH

1923

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Occupation		Residence		Manner of Death	
Signature of Physician		Signature of Registrar		Signature of Coroner	
Date of Certificate		Place of Issue		Official Seal	



TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7558

CERTIFICATE OF DEATH

07532

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore Co.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 2 2</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 53</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7506 School Ave.</b>				d. STREET ADDRESS <b>7506 School Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JAMES A. BERES</b> First Middle Last				4. DATE OF DEATH Month <b>July</b> Day <b>30</b> Year <b>19 59</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/18/1909</b>		9. AGE (In years last birthday) <b>49</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor (Employment) P.B.R. RR</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		
13. FATHER'S NAME <b>Stanley Beres</b>			14. MOTHER'S MAIDEN NAME <b>Anna Biedronski</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Irene Beres 7506 School Ave Balto. 22</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiovascular chg</b> DUE TO (c) <b>2 years</b> INTERVAL BETWEEN ONSET AND DEATH <b>min.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7-10</b> , 19 <b>57</b> , to <b>7-30</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7-15</b> , 19 <b>59</b> , and that death occurred at <b>4 pm</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Jack C Collins</b>				ADDRESS (Street, city or town, state) <b>Balt 22 Md</b>		DATE SIGNED <b>7-31-59</b>	
PHYSICIAN'S NAME (Type) <b>Jack C Collins</b>				M.D. <b>R. Kershner</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/3/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Heber</b>				ADDRESS <b>401 S. Chester St</b>		24a. REC'D BY REGISTRAR <b>DATE AUG 3 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>William S. Kraus</b>			



07533

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>✓</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Dundalk</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> <i>3Y01-4</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Chesapeake Furn. Co.</i>		d. STREET ADDRESS <i>1727 Freedomway North</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>William</i> <i>H. Berghausen</i>		4. DATE OF DEATH Month <i>7</i> Day <i>20</i> Year <i>1959</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>8-2-1907</i>	
9. AGE (In years last birthday) <i>57</i> yrs.		IF UNDER 1 YEAR Months <i>7</i> Days <i>20</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Hardware</i>	
11. BIRTHPLACE (State or foreign country) <i>Penna.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Henry Berghausen</i>		14. MOTHER'S MAIDEN NAME <i>Louisa Scott Storr</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Lauretta Berghausen</i>		Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CORONARY OCCLUSION</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>420.1</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>M. B. Davis MD</i>		DATE SIGNED <i>7/20/59</i>	
EXAMINER'S NAME (Type) <i>M. B. DAVIS MD</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7-21-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>-</i>		22d. LOCATION (City, town, or county) (State) <i>Scranton, Penna.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Rd.</i>	
24a. REC'D BY REGISTRAR DATE <i>JUL 22 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Huns</i>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. The certificate should be executed by the medical examiner, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7559 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07534

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>City</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland.</u>		c. LENGTH OF STAY IN 1b <u>24 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rosewood State Training School</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Maryland.</u> 3491-4	
f. STREET ADDRESS <u>3303 Fleet Street</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Zelma</u> Middle <u>BETCH</u> Last <u>BETCH</u>		4. DATE OF DEATH Month <u>7</u> Day <u>6</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/6/25</u>
9. AGE (In years last birthday) <u>34</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>  </u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Betch (deceased)</u>	
14. MOTHER'S MAIDEN NAME <u>Annie <del>Smith</del> (deceased)</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Rosewood Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> DUE TO <u>Fractured left femur</u> Conditions, if any, which gave rise to immediate cause (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>8 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>quadraplegic (since birth); decubitus ulcer (6-months)</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <u>Fell out of bed.</u>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>		
20c. TIME OF INJURY Month <u>6</u> Day <u>27</u> Year <u>59</u> Hour <u>11</u> a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rosewood S.T. Schl. Owings Mills Balto.</u>	20f. (City or town) (County) (State) <u>BALTO. MD.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>D.D. Caples</u>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>D.D. Caples, M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL 7-9-59</u>	22b. DATE THEREOF <u>7-9-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. CARMEL CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>5712 O'DONNELL ST BALTO. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Gerls</u>		24a. REC'D BY REGISTRAR <u>9015 CONKLING ST. BALTO. MD.</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

MEDICAL CERTIFICATION



1  
100-11132  
100-11132



7552 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

100-11132

Blank medical examiner's certificate form with faint grid lines and mirrored text from the reverse side.



## CERTIFICATE OF DEATH

Reg. Dist. No.

07535

7560

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>		c. LENGTH OF STAY IN 1b <b>6 MONTHS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>KATHERINE ELIZABETH BEVANS</b>		4. DATE OF DEATH Month Day Year <b>JULY 11 1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-18-1883</b>
9. AGE (In years last birthday) <b>75 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>GEORGE VOHLAND</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH RUHL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-12-0317</b>	
17. INFORMANT <b>Frank L. Smith Jr.</b>		Address <b>Cockeysville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis cordis-vascular</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month Day Year <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 16 1959</b> , to <b>July 11 1959</b> , that I last saw the deceased alive on <b>July 11 1959</b> , and that death occurred at <b>8:00</b> M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <b>Cockeysville, Md.</b>		DATE SIGNED <b>7/11/59</b>	
ACTUAL SIGNATURE <b>Elizabeth B. Sherrill</b>		M.D. <b>Cockeysville, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Elizabeth B. Sherrill</b>		<b>Cockeysville, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>7-15-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street</b>		24a. REC'D BY REGISTRAR <b>DATE JUL 14 '59</b>	
24b. REG. STAR'S SIGNATURE <b>Arthur L. Kuma</b>			

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7561

## CERTIFICATE OF DEATH

Reg. Dist. No. 07536

1 PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2217 Powers Lane</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <i>John Henry Beyold</i>		4. DATE OF DEATH Month Day Year <i>July 4 1959</i>	
5 SEX <i>M</i>	6 COLOR OR RACE <i>White</i>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>11/13/68</i>
9 AGE (In years last birthday) yrs. <i>90</i>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>	
10b. KIND OF BUSINESS OR INDUSTRY <i>Shooter Cont.</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Adam Beyold</i>	
14. MOTHER'S MAIDEN NAME <i>Catherine Bloom</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>	
16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT <i>John C. Beyold</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Degenerative C. V. Disease</i> DUE TO <i>Generalized Arterio Sclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>15 yrs.</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1 WEEK</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>6-1</i> , 19 <i>58</i> , to <i>7-4</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>7-4</i> , 19 <i>59</i> , and that death occurred at <i>10:4</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Jessie Estowes</i> M.D.		ADDRESS (Street, city or town, state) <i>Catonsville</i> DATE SIGNED <i>7-5</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVA. (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>7/7/59</i>	<i>Cathedral</i>	<i>Balto. Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Habb &amp; Son</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 6 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Charles E. Knud</i>	

TO HOSPITAL OR TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7562

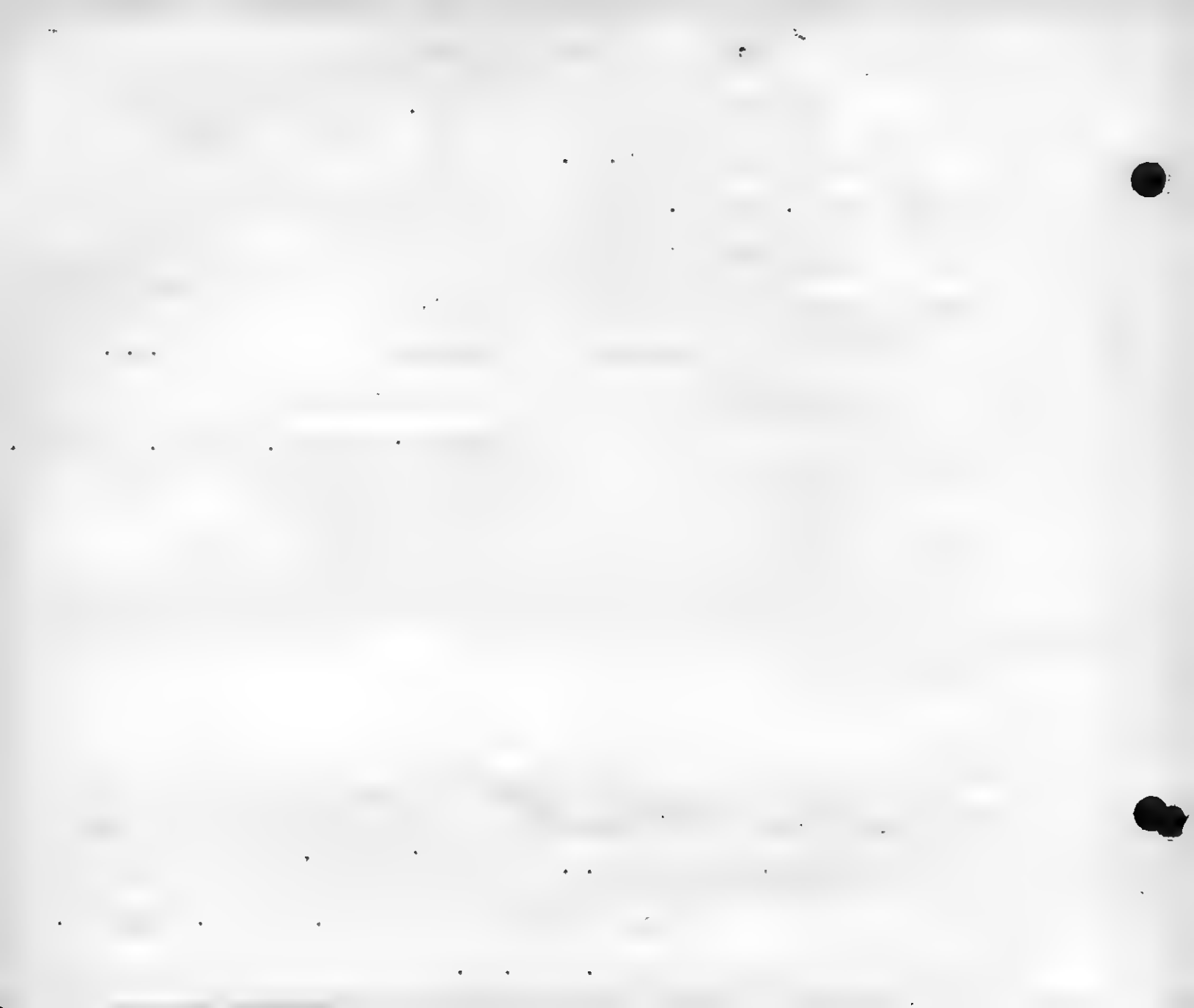
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Convent, 1001 W. Joppa Rd.</b>				d. STREET ADDRESS <b>1001 West Joppa Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sister Mary Benigna (Bohan)</b>				4. DATE OF DEATH Month Day Year <b>July 2, 1959</b>			
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 16, 1871</b>		9. AGE (in years last birthday) <b>88 yrs.</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nun</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Convent</b>		11. BIRTHPLACE (State or foreign country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Cormick Bohan</b>				14. MOTHER'S MAIDEN NAME <b>Brigid Smyth</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Convent Records, 1001 W. Joppa Rd, Towson, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 24 Hrs.							
420.1 DUE TO (b) <b>Hypertensive Cardio Renal</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>Vascular Disease</b> 10 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Oct 6, 1948</b> to <b>July 2, 1959</b> , that I last saw the deceased alive on <b>12</b> and that death occurred at <b>M</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Charles F. O'Donnell, M.D.</b>				ADDRESS (Street, city or town, state) <b>7501 York Road Towson, Md.</b>		DATE SIGNED <b>7/2/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>7/4/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Convent Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>1001 W. Joppa Rd. Towson, Md.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lo Vernon Gannon</b>				ADDRESS <b>4611 Park Hgts. Balto. Md.</b>		24a. REC'D BY REGISTRAR <b>DATE JUL 6 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles S. Knecht</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7563 Item 14 Filed 14 7-14-59  
CERTIFICATE OF DEATH

07537

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 16 Fusting Ave		d. STREET ADDRESS 1528 Uniford Rd	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harry Middle S Last Bird Sr.		4. DATE OF DEATH Month 7 Day 4 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/4/1877
9. AGE (In years last birthday) 82 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) retired painter		10b. KIND OF BUSINESS OR INDUSTRY R.R.	
11. BIRTHPLACE (State or foreign country) Philadelphia Pa.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Henry S. Bird		14. MOTHER'S MAIDEN NAME Lena (maiden name unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address ? Mr. Harry S. Bird Jr 1528 Uniford Rd/			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Lobar Pneumonia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic Hypertensive Cardio-Vascular Disease</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 da. 10 yrs (?)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour o. m. p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-3-1959, to 7-4-1959, that I last saw the deceased alive on 7-3-1959, and that death occurred at 11:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Wilmer K. Gallagher</i>		DATE SIGNED 7-5-59	
PHYSICIAN'S NAME (Type) <i>Wilmer K. Gallagher</i>		ADDRESS (Street, city or town, state) <i>6209 Fendrick Rd. Baltimore - 25, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 7/5/59	22c. NAME OF CEMETERY OR CREMATORY Northwood Cemt.	22d. LOCATION (City, town, or county) (State) Phila. Pa.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. T. Ticker</i>		24a. REC'D BY REGISTRAR <i>Arthur L. Hines</i>	
24b. REGISTRAR'S SIGNATURE		DATE JUL 8 '59	



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7554

## CERTIFICATE OF DEATH

Reg. Dist. No.

07538

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 7 X</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>3610 Essex Road</b>		d. STREET ADDRESS <b>3610 Essex Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>DOROTHY</b> Middle <b>I.</b> Last <b>BLIZZARD</b>		4. DATE OF DEATH Month <b>July</b> Day <b>12</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 28, 1917</b>
9. AGE (In years lost birthday) <b>42 yrs</b>		IF UNDER 1 YEAR Months <b>42</b> Days <b>12</b> Hours <b>19</b> Min <b>59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Peyton Nowlin</b>		14. MOTHER'S MAIDEN NAME <b>Pearl - (unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Joan A. Keenan - 3034 Huron Ave.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA TOSIS</b> <b>111X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <b>CARCINOMA of CERVIX</b> DUE TO (c) <b>34RS.</b> INTERVAL BETWEEN ONSET AND DEATH <b>6 MONTHS</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>19</b> Month <b>19</b> Day <b>19</b> Year <b>19</b> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>19 56</b> , to <b>19 59</b> , that I last saw the deceased alive on <b>July 11</b> , <b>19 59</b> , and that death occurred at <b>2 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1715 Eastern Rd</b> DATE SIGNED ACTUAL SIGNATURE <b>Earle M. Wilder, M.D.</b> PHYSICIAN'S NAME (Type) <b>EARLE M. WILDER, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/15/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James J. ...</b>		24a. REC'D BY REGISTRAR <b>DAUL 15 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. ...</b>			



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7564

## CERTIFICATE OF DEATH

07539

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) b. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville 28</b>		c. LENGTH OF STAY IN 1b <b>55 Towson 4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Summit Nursing Home 98 Smithwood Avenue</b>		d. STREET ADDRESS <b>6317 Bamberry Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Emma</b> Middle <b>R</b> Last <b>Bode</b>		4. DATE OF DEATH Month <b>July</b> Day <b>27</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 12, 1875</b>
9. AGE (In years last birthday) yrs. <b>84</b>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William H. Bode</b>		14. MOTHER'S MAIDEN NAME <b>Henrietta E. Conrad</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>none</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>S. Allen Hechter, 6 Club Road, Baltimore 10</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.2 Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute &amp; chronic</b> DUE TO <b>Degenerative Heart Disease</b> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 1959</b> to <b>7/27/59</b> , that I last saw the deceased alive on <b>7/26/59</b> , 19, and that death occurred at <b>345P M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <b>W. E. Mc Grath</b> M.D.		<b>1303 Frederick Rd</b>	
PHYSICIAN'S NAME (Type) <b>W. E. Mc Grath</b>		<b>Catonsville 28md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-29-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Govans Presbyterian Church Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Govans 12, Baltimore Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 29 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>			





**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**7565** **CERTIFICATE OF DEATH**

Reg. Dist. No.

07540

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>12yr9mths</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills, Maryland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>Ritters Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Howard</b> Last <b>Bowen</b>				4. DATE OF DEATH Month <b>7</b> Day <b>26</b> Year <b>1959</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 13, 1883</b>		9. AGE (In years last birthday) <b>76</b> yrs	IF UNDER 1 YEAR Months <b>7</b> Days <b>26</b>	IF UNDER 24 HRS Hours <b>19</b> Min <b>59</b>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Franklin Bowen</b>				14. MOTHER'S MAIDEN NAME <b>Laura Virginia Jeffries</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO <b>Unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypotension</b> <b>x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Uncontrolable Diabetes</b> DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>1946-1959</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 21</b> 19 <b>59</b> , to <b>July 26</b> 19 <b>59</b> , that I last saw the deceased alive on <b>July 26</b> 19 <b>59</b> , and that death occurred at <b>7<sup>00</sup> A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>7/26/59</b>							
ACTUAL SIGNATURE <b>BRUNO RADAUSKAS</b>		PHYSICIAN'S NAME (Type) <b>BRUNO RADAUSKAS</b> <b>Catonsville 28, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 28/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F.Eline &amp; Sons, Reisterstown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7566

CERTIFICATE OF DEATH

Reg. Dist. No. 07541

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>2 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Stella Maris Hospice—Towson—Md.</u>		d. STREET ADDRESS <u>5607 Gardenville Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Lydia</u> Middle <u>Braker</u> Last <u>Braker</u>		4. DATE OF DEATH Month <u>7</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/10/1886</u>
9. AGE (In years last birthday) <u>72</u> yrs		IF UNDER 1 YEAR: Months <u>7</u> Days <u>25</u> Hours <u>15</u> Min <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Aberdeen, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Cullum</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Preston</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Charles F. O'Donnell</u>		Address <u>Towson, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>522x</u> DUE TO <u>Terminal Extremity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Unrecorded</u> DUE TO <u>Unrecorded</u> (c) <u>Unrecorded</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>15 hours</u> <u>10 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 1, 1957</u> to <u>July 25, 1959</u> that I last saw the deceased alive on <u>July 25, 1959</u> and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>Towson, Md.</u> DATE SIGNED <u>7/26/59</u> ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell—M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>7-28-59</u>		22b. DATE THEREOF <u>7-28-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Funeral &amp; Burial 5305 Bayford</u>		24a. REC'D BY REGISTRAR <u>DATE 28 59</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles E. Kneass</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7567

## CERTIFICATE OF DEATH

07542

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>6yr27dys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>100 Burnett Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Branigan</b> Last				4. DATE OF DEATH Month <b>July</b> Day <b>27</b> Year <b>19 59</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>separated</b> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 3, 1885</b>		9. AGE (In years last birthday) <b>74</b> yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>domestic</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>(Unknown) Baltimore, Md.</b>	
13. FATHER'S NAME <b>(Unknown) Joseph Branigan</b>				14. MOTHER'S MAIDEN NAME <b>Unknown (Mary)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>unknown</b>				16. SOCIAL SECURITY NO <b>212-12-9310</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>July 6</b> , 19 <b>59</b> , to <b>July 27</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>July 27</b> , 19 <b>59</b> , and that death occurred at <b>10:00p</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stella Wachslar</b>				ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b>			
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>				DATE SIGNED <b>7-28-59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>JULY 30, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>	
						22d. ADDRESS <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>FLYNN &amp; FLEMING, INC.</b>				24a. REC'D BY REGISTRAR <b>1422 Light St.</b>		24b. REGISTRAR'S SIGNATURE <b>Baltimore, Maryland</b>	
				DATE <b>JUL 30 59</b>			

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7568

## CERTIFICATE OF DEATH

07543

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Towson</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Towson</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenarm Road</b>				d. STREET ADDRESS <b>Glenarm Road</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sister Mary Trinidad Brazaitis</b>				4. DATE OF DEATH Month Day Year <b>July 20 1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 22, 1885</b>	
9. AGE (In years last birthday) <b>73 yrs</b>		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Jacksons, Pa.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Joseph Brazaitis</b>				14. MOTHER'S MAIDEN NAME <b>Ursula Mitzeianski</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Sr. M. Peter Fourier</b>	
				Address <b>Notbth Cliff, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive cardio-renal disease</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>  <b>10 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) <b>Towson, Md.</b>		(County) (State)	
21. I certify that I attended the deceased from <b>July 1953</b> , to <b>July 1959</b> , that I last saw the deceased alive on <b>June 23, 1959</b> , and that death occurred at <b>9.55 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7501 York Road Towson, Md.</b> DATE SIGNED <b>7/20/59</b>							
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>				PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>BURIAL</b>		<b>7-22-59</b>		<b>VILLA MARIA CEM.</b>		<b>NOTCH CLIFF NATON, MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Home Bldg. 24 Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 22 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneel</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 7569 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riderwood</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ruxway Manor</u>		e. STREET ADDRESS <u>5118 Whiteford Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elizabeth Barbara Brickman</u>		4. DATE OF DEATH Month Day Year <u>July 23 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 28, 1866</u>
9. AGE (In years last birthday) yrs <u>92</u>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George A. Keller</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Nugent</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>***</u>	
17. INFORMANT <u>M. Isabelle Keller</u>		Address <u>Above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CEREBRO VASCULAR HEMORRHAGE</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROSIS, GENERALIZED</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10/26</u> , 19 <u>57</u> , to <u>7/23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7/22</u> , 19 <u>59</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>T. C. Siwinski</u>		ADDRESS (Street, city or town, state) <u>17 W PENNA. AVE</u>	
PHYSICIAN'S NAME (Type) <u>T.C. SIWINSKI</u>		DATE SIGNED <u>7/24/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-25-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. Jenkins &amp; Sons Co.</u>		ADDRESS <u>4905 York Rd.</u>	
24a. REC'D BY REGISTRAR <u>JUL 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>William A. Thomas</u>	

TO HOSPITAL OR PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7570 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **07545**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN IB <b>24 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b></b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3704 Dennlyn Road</b>									
<b>3. NAME OF DECEASED</b> (Type or print) First <b>IVAN</b> Middle <b>L.</b> Last <b>BRIGGS</b>				<b>4. DATE OF DEATH</b> Month <b>July</b> Day <b>31</b> Year <b>1959</b>									
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>Negro</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Oct. 19, 1907</b>		<b>9. AGE</b> (In years last birthday) <b>51 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months <b></b> Days <b></b>		<b>IF UNDER 24 HRS.</b> Hours <b></b> Min. <b></b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Library Clerk</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Social Security</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Cumberland, Maryland</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>Charles Briggs</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Olivia Smith</b>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> <b>WW II</b>				<b>16. SOCIAL SECURITY NO.</b> (If yes, give war or dates of service) <b>217-05-6589</b>		<b>17. INFORMANT</b> Address <b>Clin. Records, VA Hosp., Ft. Howard, Md.</b>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Pulmonary Edema due to Hypertensive and Arteriosclerotic Renal Disease</b> <b>442X DUE TO</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</b> <b>(b)</b> <b>DUE TO</b> <b>(c)</b>													
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>Multiple Fractures of Lower Extremities</b>													
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Fell out of 3rd floor window</b>									
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>Hour</b> <b>9:30</b> <b>AM</b> <b>7/17/59</b> <b>p. m.</b>				<b>20d. INJURY OCCURRED</b> <b>While at work</b> <input type="checkbox"/> <b>Not while at work</b> <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>hospital</b>		<b>20f. (City or town)</b> <b>Ft. Howard Hosp. Baltimore Md.</b>		<b>(County)</b> <b></b> <b>(State)</b> <b></b>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> <b>Natural causes</b> <input type="checkbox"/> <b>Accident</b> <input checked="" type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined cause</b> <input type="checkbox"/>													
<b>ACTUAL SIGNATURE</b> <i>Charles S. Petty</i>						<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>8/2/59</b> <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>							
<b>EXAMINER'S NAME (Type)</b> <b>Charles S. Petty</b>						<b>DATE SIGNED</b>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>				<b>22b. DATE THEREOF</b> <b>Aug 4, 1959</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Baltimore National</b>				<b>22d. LOCATION (City, town, or county)</b> <b>Baltimore, Maryland</b>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Arlington S. Phillips</b>						<b>ADDRESS</b> <b>1808 N. Monroee St.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE AUG 3 '59</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Charles S. Petty</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please advise the Chief Medical Examiner's Office in writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained for your files. Forward to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7571

CERTIFICATE OF DEATH

Reg. Dist. No.

07546

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Ba7to</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson</b>		c. LENGTH OF STAY IN 1b <b>42 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>		e. STREET ADDRESS <b>2607 Sparrows Pt. Rd</b>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Issac</b> Middle <b>Taylor</b> Last <b>Brooks</b>		4. DATE OF DEATH Month <b>7</b> Day <b>7</b> Year <b>1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/3/1897</b>
9. AGE (In years last birthday) <b>61 yrs</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel</b>	
11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Walter Brooks</b>		14. MOTHER'S MAIDEN NAME <b>Martha Wheeler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>228-10-1730</b>	
17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>For Advanced Pulmonary Tuberculosis</b> <b>002a</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/26</b> , 19 <b>55</b> , to <b>7/7</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7/7</b> , 19 <b>54</b> , and that death occurred at <b>6:40 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>William Newcomer</b> M.D.		Mt. Wilson, Maryland	
PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>		Superintendent	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>July 7, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Family Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Spotsylvania Co., Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles H. Newell, Pikesville Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 10 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			





TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7572

## CERTIFICATE OF DEATH

Reg. Dist. No. 07547

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Forest Haven Nurs.Ho.315 Ingleside Ave</b>				d. STREET ADDRESS <b>1239 Greystone Rd.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE S. BROWN</b>				4. DATE OF DEATH Month Day Year <b>July 26, 1959</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Mar. 10, 1899</b>	
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>male nurse</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>male nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>George Brown</b>				14. MOTHER'S MAIDEN NAME <b>Margaret -</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>yes</b> (If yes, give war or dates of service) <b>World War I</b>				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Mrs. Dorothy Thomas-1239 Greystone Rd., Arbutus</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MASSIVE CEREBRAL HEMORRHAGE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIO-SCLEROTIC HEART</b> DUE TO (c) <b>UNSTABLE GLUCOSE - DIABETES</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>7/1</b> , 19 <b>59</b> , to <b>7/26</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7/25</b> , 19 <b>59</b> , and that death occurred at <b>11 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>John H. Shaw M.D. 8800 Edmonson Ave 7/28/59</b>							
ACTUAL SIGNATURE <b>John H. Shaw M.D.</b>				PHYSICIAN'S NAME (Type) <b>John H. Shaw M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/29/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. ...</b>				24a. REG'D BY REGISTRAR DATE <b>JUL 29 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. ...</b>	



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7573

## CERTIFICATE OF DEATH

Reg. Dist. No.

07548

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>23 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
3. NAME OF DECEASED (Type or print) First <b>JEROME</b> Middle <b>F.</b> Last <b>BROWN</b>		d. STREET ADDRESS <b>707 West Lanvale Street (17)</b>	
4. DATE OF DEATH Month <b>July</b> Day <b>5</b> Year <b>19 59</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>January 14, 1909</b>
9. AGE (In years last birthday) <b>50</b>		IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic - Automobile</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Body and Fender Co. Baltimore, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <b>Jesse Brown</b>		14. MOTHER'S MAIDEN NAME <b>Eva Roberts</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b> <b>WW II</b>		16. SOCIAL SECURITY NO <b>216-05-2299</b>	
17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMA OF ESOPHAGUS WITH METASTASIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>UNKNOWN</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 12</b> , 19 <b>59</b> , to <b>July 5</b> , 19 <b>59</b> , and that death occurred at <b>8:30 P</b> M, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>VA, FORT HOWARD, MARYLAND</b> <b>7/6/59</b> ACTUAL SIGNATURE <b>John W. Crawford</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b> PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b> <b>VAH, FORT HOWARD, MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-10/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cathedral Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Earl Gilmore Funeral Home</b>		24a. REC'D BY REGISTRAR <b>JUL 10 1959</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>		DATE	



TO DEPUTY: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the cause in writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7715 South Western Blvd		d. STREET ADDRESS 815 Hill To Rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joseph A. Browne		4. DATE OF DEATH July 3, 59		5. SEX Male	
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 2, 1912	
9. AGE (In years last birthday) 46 yrs.		10. UNDER 1 YEAR Months Days Hours Min.		11. UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President Building Supply		10b. KIND OF BUSINESS OR INDUSTRY Building Supply		11. BIRTHPLACE (State or foreign country) Penn	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Albert Browne		14. MOTHER'S MAIDEN NAME Eva Chatter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 21724 6847		17. INFORMANT Mrs Helen K Browne	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Killed by being crushed by load of lumber 410.3 DUE TO slipping of machine Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO Head and body badly crushed, Accident		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Load of lumber slipped from machine falling on man	
20c. TIME OF INJURY Hour 2 PM Month, Day, Year July 3, 59		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Factory	
20f. (City or town) Halethorpe		20g. (County) Baltimore		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE Geo. S. M. Kieffer M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED July 3, 59	
EXAMINER'S NAME (Type) Geo. S. M. Kieffer M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/6/59		22c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.	
22d. LOCATION (City, town, or county) Elkridge, Md.		22e. REC'D BY REGISTRAR DATE JUL 8 '59		22f. REGISTRAR'S SIGNATURE Arthur S. Kieffer	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7574

## CERTIFICATE OF DEATH

Reg. Dist. No.

07550

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b>		c. LENGTH OF STAY IN 1b <b>34 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1127 "H" Street</b>		d. STREET ADDRESS <b>1127 "H" Street</b>	
3. NAME OF DECEASED (Type or print) First <b>HERMAN</b> Middle <b>+++</b> Last <b>BYROADE</b>		4. DATE OF DEATH Month <b>July</b> Day <b>14th</b> Year <b>1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 31, 1925</b>
9. AGE (In years last birthday) <b>34</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dye Maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Dean W. Byroade</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Moore</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>216-28-9945</b>	
17. INFORMANT <b>D.W. Byroade</b>		Address <b>same as #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>---</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1, 1959</b> to <b>July 14, 1959</b> that I last saw the deceased alive on <b>July 12, 1959</b> and that death occurred at <b>1:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>5200 St, Balt 19 7.15</b>			
ACTUAL SIGNATURE <b>R G WINDSOR</b>		M.D. <b>5200 St, Balt 19</b>	
PHYSICIAN'S NAME (Type) <b>R G WINDSOR</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 18, 59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Co., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradley, Inc., Dundalk 22, Md</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 20 '59</b>	
ADDRESS <b>Walter Brooks Bradley, Inc., Dundalk 22, Md</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Thomas</b>	





TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
Item 7, Film 6245, 7/24/59											
7575											
CERTIFICATE OF DEATH											
Reg. Dist. No. 07551											
1. PLACE OF DEATH a. COUNTY <u>Roger Carter Balto., Co. MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville, Maryland</u>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>34 Winters Lane</u>					d. STREET ADDRESS <u>34 Winters Lane</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Roger Carter</u> Middle <u></u> Last <u></u>					4. DATE OF DEATH Month <u>July</u> Day <u>13</u> Year <u>59</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/1/37</u>		9. AGE (In years last birthday) <u>21</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min <u></u>			
13. FATHER'S NAME <u>Roger Carter</u>					14. MOTHER'S MAIDEN NAME <u>Dora Hopkins</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT <u>Margaret Hopkins 34 Winters Lane</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Status Epilepticus</u>								INTERVAL BETWEEN ONSET AND DEATH <u>4 Days</u>			
DUE TO <u>Epilepsy (Grand Mal)</u> Several years											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>(Grand Mal)</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>July 6th, 1959</u> , to <u>July 13, 1959</u> , that I last saw the deceased alive on <u>July 13, 1959</u> , and that death occurred at <u>3.00 P.M.</u> from the causes and on the date stated above.											
ACTUAL SIGNATURE <u>C. F. Maloney</u>					ADDRESS (Street, city or town, state) <u>57 Winters Lane, Balto.</u>					DATE SIGNED <u>7/13/59</u>	
PHYSICIAN'S NAME (Type) <u>C. F. Maloney, M.D.</u>											
22a. BURIAL, CREMATION, or MOVING (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/16/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Carver Memorial Park</u>			22d. LOCATION (City, town, or county) (State) <u>Murkirk, Md.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles A. Rice</u>					ADDRESS <u>661 W. Barre Street</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 20 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Charles A. Rice</u>		



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08753

7576

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				d. STREET ADDRESS <u>8902 Baltimore Boulevard</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Eugene</u> First <u>Casey</u> Middle <u>Casey</u> Last				4. DATE OF DEATH Month <u>July</u> Day <u>20</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Unknown</u>	
9. AGE (In years last birthday) <u>45?</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>		IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Unknown</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis of liver</u>							
581.0 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
(b) DUE TO							
(c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> Month <u>  </u> Day <u>  </u> Year <u>  </u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <u>June 27</u> , 19 <u>59</u> , to <u>July 20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 20</u> , 19 <u>59</u> , and that death occurred at <u>5:30p</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stella Wachslar</u>				ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u>7-22-59</u>			
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>				<u>Catonsville 28 Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>8/15/59</u>		<u>Cathedral</u>		<u>4300 Oak Indemnity</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Foley &amp; Sons</u>				ADDRESS <u>1318 Light</u>		24a. REC'D BY REGISTRAR <u>  </u> DATE <u>AUG 17 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>C. J. L. Kneale</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7577

CERTIFICATE OF DEATH

07552

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ma.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8344 Ridgeley Oak Rd.</u>		d. STREET ADDRESS <u>8344 Ridgeley Oak Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>A.</u> Last <u>Cockerill</u>		4. DATE OF DEATH Month <u>July</u> Day <u>31</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-17-1919</u>
9. AGE (In years last birthday) <u>40</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frederick Ackerman</u>		14. MOTHER'S MAIDEN NAME <u>Lillian Hinkle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>James J. Cockerill</u> Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>Chronic glomerulonephritis</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <u>Diabetic arteriosclerosis</u> (c) <u>Diabetes mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>14</u> <u>4 1/2</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 31, 1959</u> to <u>July 31, 1959</u> , that I lost the deceased alive on <u>August 1, 1959</u> , and that death occurred at <u>3:45 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Joseph F. Hinkle, M.D.</u> <u>8344 Ridgeley Oak Rd.</u> <u>7-31-59</u> <u>1. J. F. Hinkle, M.D.</u> <u>1. Le Pira, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/3/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO</u> <u>MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Rd.</u>	24a. REC'D BY REGISTRAR DATE <u>AUG 3 '59</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



## 7578 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07553

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk (22)</b>		c. LENGTH OF STAY IN 1b <b>3 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6725 Thruway</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Warren</b> Middle <b>WILLIAM</b> Last <b>COLEMAN</b>		4. DATE OF DEATH Month <b>July</b> Day <b>31st</b> Year <b>1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 3, 1915</b>
9. AGE (In years last birthday) <b>43</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Checker</b>	
11. BIRTHPLACE (State or foreign country) <b>Danville, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Coleman</b>		14. MOTHER'S MAIDEN NAME <b>Hannah ???</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>202-09-7677</b>	
17. INFORMANT <b>Ella S. Coleman</b>		Address <b>same as #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic H.D.</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b> <b>2 yrs</b>			
MEDICAL CERTIFICATION 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Jack C. Collins</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Jack C. Collins, M.D.</b>		DATE SIGNED <b>8/1/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/4/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Co., Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradley, Inc.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 3 '59</b>	
ADDRESS <b>Dundalk 22</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please see the certificate for instructions. Write the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7579

## CERTIFICATE OF DEATH

Reg. Dist. No.

07554

1. PLACE OF DEATH a. COUNTY <u>Baltimore - 19</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ft. Howard</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Avenue B.</u>		d. STREET ADDRESS <u>#1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN THOMAS CONNOR</u>		4. DATE OF DEATH Month Day Year <u>July 16 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 16 1885</u>
9. AGE (In years last birthday) <u>74</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Press operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>215 01-0141</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Connor</u>		14. MOTHER'S MAIDEN NAME <u>Ida Mills</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>215 07-0141</u>	
17. INFORMANT <u>Lillian Connor (wife)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) <u>Myocardial infarction</u> <u>Hypertensive Cardio Vascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>7 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 23</u> , 19 <u>59</u> to <u>July 16</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 1</u> , 19 <u>59</u> , and that death occurred at <u>8 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis N. Tollin</u> M.D.		ADDRESS (Street, city or town, state) <u>6908 N. POINT RD. BALTO-MD</u>	
DATE SIGNED <u>7/16/59</u>			
PHYSICIAN'S NAME (Type) <u>LOUIS N. TOLLIN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/20/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Belair Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Belair, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home 2112 Dundalk Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 20 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Carlton S. Knecht</u>			



7580

## CERTIFICATE OF DEATH

07555

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Foxleigh Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bessie</u> First <u>Cooper</u> Middle Last		4. DATE OF DEATH <u>7-10-1959</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Isaac Caplan</u>		14. MOTHER'S MAIDEN NAME <u>Not Known</u>	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Henry Robinson - Same</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of lung with metastases</u> X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-8-1959</u> to <u>present</u> , that I last saw the deceased alive on <u>7-8-1959</u> , and that death occurred at <u>4A</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bernard Burgin</u> M.D.		ADDRESS (Street, city or town, state) <u>6721 Reisterstown Rd. Balto Md</u> DATE SIGNED <u>7/10/59</u>	
PHYSICIAN'S NAME (Type) <u>BERNARD BURGIN</u>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-12-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Hebrew</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis Inc</u> ADDRESS <u>2100 Eutan Place</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 14 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7581

## CERTIFICATE OF DEATH

## 07556

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			c. LENGTH OF STAY IN 1b <b>1yr18mth13dys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>1200 Carroll Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Wallace</b> Last <b>Covington</b>				4. DATE OF DEATH Month <b>July</b> Day <b>29</b> Year <b>1959</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 28, 1905</b>	9. AGE (In years last birthday) <b>54</b> yrs	10. IF UNDER 1 YEAR: IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>tool and die maker</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Revere Copper</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>William Covington</b>				14. MOTHER'S MAIDEN NAME <b>Helen Wallace</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>C-3-458-684</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>218-05-7618</b>		17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 15, 1957</b> , to <b>July 29, 1959</b> , that I last saw the deceased alive on <b>July 29, 1959</b> , and that death occurred at <b>9:40a</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stella Wachslor</b>				ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b>			
PHYSICIAN'S NAME (Type) <b>Stella Wachslor, M. D.</b>				DATE SIGNED <b>7-29-59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7-31-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 31 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. [Signature]</i>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.









# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7583 CERTIFICATE OF DEATH

07558

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>3 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>2011 McCulloh Street (17)</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>W.</b> Last <b>CROXTON</b>		4. DATE OF DEATH Month <b>July</b> Day <b>24</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 24, 1888</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months <b>71</b> Days <b>71</b> Hours <b>71</b> Min <b>71</b>	11. IF UNDER 24 HRS Months <b>71</b> Days <b>71</b> Hours <b>71</b> Min <b>71</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Scrap Yard</b>	
11. BIRTHPLACE (State or foreign country) <b>Lancaster Co., Virginia</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ned Croxton</b>		14. MOTHER'S MAIDEN NAME <b>Bertha Williams</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>217-05-8121</b>	
17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RETROPERITONEAL FIBROSARCOMA</b> <b>158X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Operation 2/6/59 Transverse Colostomy</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 21</b> , 19 <b>59</b> , to <b>July 24</b> , 19 <b>59</b> , and that death occurred at <b>3:20 AM</b> , from the causes and on the date stated above <b>John W. Crawford</b> ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>7/24/59</b>			
ACTUAL SIGNATURE <b>John W. Crawford</b>		M.D. <b>VAH, FORT HOWARD, MARYLAND</b>	
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>		VAH, FORT HOWARD, MARYLAND <b>7/24/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-28-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>George G. Kelson</b> ADDRESS <b>1348 N. Calhoun St. Balto., Md.</b>		24a. REC'D BY REGISTRAR <b>JUL 27 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kiana</b>			

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

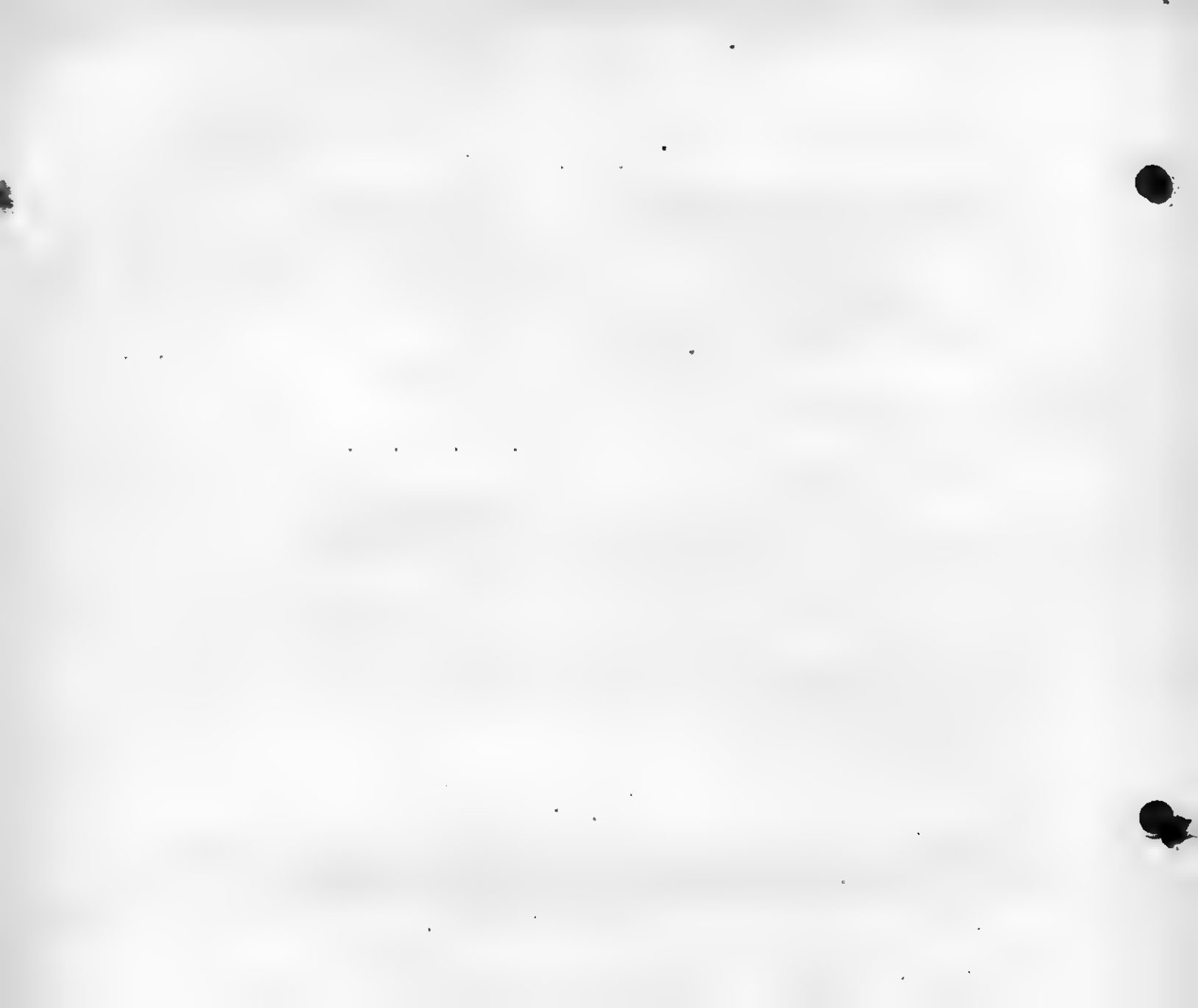
7584

## CERTIFICATE OF DEATH

Reg. Dist. No.

07559

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>16 Hrs. 50 M.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>503 Cumberland Street</b>			
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>B.</b> Last <b>CROXTON</b>				4. DATE OF DEATH Month <b>July</b> Day <b>29</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 15, 1894</b>		9. AGE (In years last birthday) yrs. <b>65</b>	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Private Family</b>		11. BIRTHPLACE (State or foreign country) <b>Heathsville, Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Charles Croxton</b>				14. MOTHER'S MAIDEN NAME <b>Helen Leland</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>				16. SOCIAL SECURITY NO. <b>217-20-0849</b>		17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE, ACUTE</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b> <b>3 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>6:00 PM 7/28, 19 59</b> to <b>8:50 AM 7/29/59</b> and that death occurred at <b>8:50 A.M.</b> from the causes and date stated above							
ACTUAL SIGNATURE <b>John W. Crawford</b>				M.D. <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>7/29/59</b>			
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>				<b>VAH, FORT HOWARD, MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-3-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		22d. LOCATION (City town or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law</b>				24a. REC'D BY REGISTRAR <b>JUL 31 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles R. Law</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7585

## CERTIFICATE OF DEATH

Reg. Dist. No.

07560

1. PLACE OF DEATH a. COUNTY <i>Baltimore - 19</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>as</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sparrows Pt.</i>		c. LENGTH OF STAY IN 1b <i>36 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>W</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7329 Lewis Ave.</i>				d. STREET ADDRESS <i>#1</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>ANTHONY</i> Middle <i>+++</i> Last <i>DAPKUS</i>				4. DATE OF DEATH Month <i>JULY</i> Day <i>12</i> Year <i>1959</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 1, 1874</i>	9. AGE (In years last birthday) <i>85</i> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Electrical repairman Steel co</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Steel co</i>		11. BIRTHPLACE (State or foreign country) <i>Lithuania</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Unknown</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>213-07-2975</i>		17. INFORMANT <i>Philomeno Long</i> Address <i>address as in #1</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Failure</i> <i>11 X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive Chronic Myocardial</i> DUE TO <i>closure</i> (c)							INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1944</i> to <i>July 12</i> , 19 <i>54</i> , that I last saw the deceased alive on <i>July 7</i> , 19 <i>54</i> , and that death occurred at <i>1A</i> M, from the causes and on the date stated above.							DATE SIGNED
ACTUAL SIGNATURE <i>Louis N. Tolkin</i>				ADDRESS (Street, city or town, state) <i>6908 N. Point Rd</i>		DATE SIGNED <i>7/12/59</i>	
PHYSICIAN'S NAME (Type) <i>Louis N. Tolkin</i>				<i>Baltimore - 19 - md</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/15/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore Co., Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walter Brooks Bradley</i>				ADDRESS <i>Sundalk 22, Md</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 14 '59</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knead</i>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7586

CERTIFICATE OF DEATH

07561

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Uppero</u>			c. LENGTH OF STAY IN 1b <u>40 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Uppero</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Emery Road</u>				d. STREET ADDRESS <u>EMERY RD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>William BRADLEY DAVIDSON</u>				4. DATE OF DEATH Month Day Year <u>July 20 1959</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 8, 1881</u>		
9. AGE (In years, last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>agriculture</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SAMPSON DAVIDSON</u>				14. MOTHER'S MAIDEN NAME <u>SALLY BROWN</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-14-0164</u>		17. INFORMANT <u>Paul Davidson, HAMPSTEAD MD</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>177X Generalized Carcinomatosis</u> DUE TO (b) <u>Primary Carcinoma of Prostate</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Atherosclerotic Cardiovascular Disease</u>								
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) _____				
20c. TIME OF INJURY Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) (County) (State) _____		
21. I certify that I attended the deceased from <u>August 15, 1958</u> to <u>July 20, 1959</u> , that I last saw the deceased alive on <u>July 20, 1959</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <u>Joseph E. Bush</u>				ADDRESS (Street, city or town, state) <u>Hampstead, Maryland</u>				
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush</u>				DATE SIGNED <u>July 20, 1959</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-23-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wesley</u>		22d. LOCATION (City, town or county) (State) <u>Wesley Co. Md</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Carl E. Tipton</u>				ADDRESS <u>Hampstead Md</u>		24a. REG'D BY REGISTRAR <u>July 24 '59</u>		
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>				





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7587 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07562

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville 28</b> c. LENGTH OF STAY IN 1b <b>28</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Paradise Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <b>1919 Breitwert Ave., Balto. City, Md.</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b> d. STREET ADDRESS <b>1919 Breitwert Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Andrew Debus</b> First Middle Last		4. DATE OF DEATH <b>July 22, 1959</b> Month Day Year	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 11, 1874</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shipping Clerk -ret.</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Continental Can</b>	
11c. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>no</b>	
17. INFORMANT <b>Nephew</b> Address <b>Wilmar Debus, 3329 Clifmont Av. Balto. 23,</b>			
18. CAUSE OF DEATH (Enter only one cause per item for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>6 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 16, 1947</b> , to <b>July 22, 1959</b> , that I last saw the deceased alive on <b>July 20, 1959</b> , and that death occurred at <b>9:07 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. Arthur Rossberg</b> M.D.		ADDRESS (Street, city or town, State) <b>2436 Washington Blvd Baltimore 30, Md.</b>	
DATE SIGNED <b>7/24/59</b>			
PHYSICIAN'S NAME (Type) <b>C. ARTHUR ROSSBERG MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/25/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Western</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore City, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul St., Balto. 2, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 27 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			



## CERTIFICATE OF DEATH

07563

Reg. Dist. No.

7588

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Mercy Villa Rest Home</i>		d. STREET ADDRESS <i>1513 Tomlaw Rd.</i>	
3. NAME OF DECEASED (Type or print) <i>Angela</i> First Middle Last <i>Delclos</i>		4. DATE OF DEATH Month <i>July</i> Day <i>1</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-31-1875</i>
9. AGE (In years last birthday) <i>83</i> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Spain</i>	
11. BIRTHPLACE (State or foreign country) <i>Spain</i>		12. CITIZEN OF WHAT COUNTRY? <i>Spain</i> ✓	
13. FATHER'S NAME <i>Anthony Reinal</i>		14. MOTHER'S MAIDEN NAME <i>Mary Joerster</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>John Delclos</i> Address <i>same</i>	
17. INFORMANT <i>John Delclos</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Occlusion</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive Arteriosclerosis</i> DUE TO (c) <i>Cardiovascular Disease</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <i>20 years</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1954</i> , 19 to <i>7/1</i> , 1959, that I last saw the deceased alive on <i>June</i> , 1959, and that death occurred at <i>3:30 P.M.</i> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Wilfred H. Townshend</i> M.D. <i>14 E. Engle St Baltimore 2</i> 7/1/59			
PHYSICIAN'S NAME (Type) <i>Wilfred H. Townshend, Jr., M. D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7-4-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Rd.</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 6 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Charles S. Evans</i>	

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7589

## CERTIFICATE OF DEATH

07564

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> 19 <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>AS</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SPARROWS Pt</b>		c. LENGTH OF STAY IN 1b <b>8 mo.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WHITE AVE</b>		d. STREET ADDRESS <b>#1</b>	
3. NAME OF DECEASED (Type or print) First <b>JULIA</b> Middle <del>XXXXXXXXXX</del> Last <b>DEMSKI</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>2</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 12, 1885</b>
9. AGE (In years last birthday) <b>73 yrs</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WALTER OLZHENSKI.</b>		14. MOTHER'S MAIDEN NAME <b>ANNA. LAMPKE.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>John. Demski (Husband)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary failure with pulmonary edema.</b> DUE TO (b) <b>Arteriosclerosis. Hypertensive.</b> DUE TO (c) <b>Cardiovascular disease.</b> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>2 hours.</b> <b>6 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 28</b> , 19 <b>58</b> , to <b>July 2</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>July 2</b> , 19 <b>59</b> , and that death occurred at <b>3 P.</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Louis N. Tollin</b> M.D.		ADDRESS (Street, city or town, state) <b>6908 N. Pt. Rd.</b> DATE SIGNED <b>July 2/59</b>	
PHYSICIAN'S NAME (Type) <b>LOUIS N. TOLLIN M.D.</b>		<b>BALTO. 19. MD</b>	
22a. BURIAL, CREMATION, or other final disposition (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-6-1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Mary</b>	22d. LOCATION (City, town, or county) (State) <b>German Hill Rd. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Duda</b>		ADDRESS <b>7922 Wise Ave. 22, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUL 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Prange</b>	



TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

7590

# CERTIFICATE OF DEATH

Reg. Dist. No. 07565

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carney</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9205 Harford Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Catherine</u> Middle <u>E.</u> Last <u>Denn</u>		4. DATE OF DEATH Month <u>July</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-17-1869</u>
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William H. Chipley</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Charles Denn 1360 Winston Ave. Balto.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Atherosclerosis</u> DUE TO (c) <u>Age</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 H.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/4</u> , 19 <u>59</u> , to <u>7/5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 5</u> , 19 <u>59</u> , and that death occurred at <u>3:00</u> A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank T. Kasik</u> M.D.		DATE SIGNED <u>9/6/59</u>	
PHYSICIAN'S NAME (Type) <u>FRANK T. KASIK</u>		<u>BALTO 14 Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-8-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chestnut Grove Cem.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 7 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraus</u>	





FOR STATE  
HEALTH DEPT.

TO DEPUTY M. EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral par. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME  
SM 2/57

7591

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07566

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colgate (24)</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colgate (24)</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>401 Oriole Ave.</b>				e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Willie</b> Middle <b>Maye</b> Last <b>Dickerson</b>				4. DATE OF DEATH Month <b>July</b> Day <b>21</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 12, 1905</b>	9. AGE (In years last birthday) <b>53 yrs</b>	IF UNDER 1 YEAR Months <b>53</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Mississippi</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>Molly Doury</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-16-5503</b>		17. INFORMANT <b>Mauric Dickerson</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CIRRHOSIS OF LIVER (ALCOHOLIC)</b> 2 1/2 yrs. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>581.1</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Hour <b>19</b> a. m. <b>0</b> p. m.	Month <b>07</b> Day <b>21</b> Year <b>19 59</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>	20f. (City or town) <b>None</b>	(County) <b>None</b>	(State) <b>None</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>M. B. Davis</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>7/21/59</b>			
REGISTER'S NAME (Type) <b>M. B. DAVIS M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>7/22/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Brookhaven Funeral Home</b>		22d. LOCATION (City, town, or county) (State) <b>Lincoln Co., Miss.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>James E. Brudzinski</b>		ADDRESS <b>1407 Eastern Ave.</b>		24a. REC'D BY REGISTRAR <b>JUL 23 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

MEDICAL CERTIFICATION

2



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

7592

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07567

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE <u>Md</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7143 Holabird Ave</u>		d. STREET ADDRESS <u>7143 Holabird Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Creola</u> Middle <u>L</u> Last <u>Dixon</u>		4. DATE OF DEATH Month <u>July</u> Day <u>5</u> Year <u>1959</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>June 5 1899</u>	
9. AGE (In years last birthday) <u>60</u>		10. FUND 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>me</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Benjamin L Friend</u>		14. MOTHER'S MAIDEN NAME <u>Sarah L Friend</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
INFORMANT <u>Mrs. Maud E. Ke</u>		Address <u>7143 Holabird</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cerebral hemorrhage</u> <u>260X</u> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Hypertension cardio-vascular disease</u> DUE TO <u>Diabetes mellitus</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 min</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 15</u> , 1957, to <u>7-5</u> , 1959, that I last saw the deceased alive on <u>7-5</u> , 1959, and that death occurred at <u>7:15 PM</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Eugene F. New</u> M.D. <u>7001 Mornington Rd</u>		PHYSICIAN'S NAME (Type) <u>Eugene F. New</u> <u>Dundalk 22, Md</u>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Removed July 6/59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Blooming Rose Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Oakland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William J. Hines</u>		ADDRESS <u>2112 Dundalk</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hunt</u>	



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7593

## CERTIFICATE OF DEATH

07568

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX (21)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX (21)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>361 STILLWATER RD.</b>		d. STREET ADDRESS <b>361 STILLWATER RD.</b>	
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>JULIA</b> Last <b>DORN</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>8</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 11, 1895</b>
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE, AT HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BALTO. MD.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>NOT KNOWN</b>		14. MOTHER'S MAIDEN NAME <b>NOT KNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>EUGENE DORN</b>		Address <b>361 STILLWATER RD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>Arteriosclerotic Cardio Vascular disease</b> DUE TO <b>Diabetes Mellitus</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 1</b> , 1957, to <b>July 8</b> , 1959, that I last saw the deceased alive on <b>July 8</b> , 1959, and that death occurred at <b>1:00 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>G. Baumgardner</b> M.D.		ADDRESS (Street, city or town, state) <b>Balls Blv md</b> DATE SIGNED <b>7/14/59</b>	
PHYSICIAN'S NAME (Type) <b>G. BAUMGARDNER</b>		<b>8557 PHILADELPHIA RD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>JULY 11, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD</b>	22d. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>George W. Hoffmann</b>		ADDRESS <b>3218 Hudson St</b>	
24a. REC'D BY REGISTRAR <b>JUL 14 '59</b>		24b. REGISTRAR'S SIGNATURE <b>C. Aug 8 Frank</b>	



TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7594

## CERTIFICATE OF DEATH

07569

Reg. Dist. No

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>5 Mos. 22 Das.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Sheppard and Enoch Pratt Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. STREET ADDRESS <b>1520 H Street, N. W.</b>		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Noah</b> Middle <b>Ernest</b> Last <b>Dorsey</b>		4. DATE OF DEATH Month <b>July</b> Day <b>6</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 15, 1873</b>
9. AGE (In years last birthday) <b>86</b> yrs		IF UNDER 1 YEAR Months <b>4</b> Days <b>14</b> Hours <b>1</b> Min <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physicist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Lloyd E. Dorsey</b>		14. MOTHER'S MAIDEN NAME <b>Laura Worthington</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>_____</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b> <b>4 d. 1</b> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Chronic myocarditis</b> DUE TO (c) <b>Generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 da</b> <b>1 yr +</b> <b>11 h</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 14, 1959</b> to <b>July 6, 1959</b> , that I last saw the deceased alive on <b>July 4, 1959</b> , and that death occurred at <b>4:20 A.M.</b> , from the causes and on the date stated above			
ACTUAL SIGNATURE <b>W. W. Elgin</b>		DATE SIGNED <b>7/6/59</b>	
PHYSICIAN'S NAME (Type) <b>W. W. Elgin, M. D.</b>		ADDRESS (Street, city or town, state) <b>The Sheppard and Enoch Pratt Hospital, Towson 4, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial July 8, 1959</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Elgin</b>		24a. REC'D BY REGISTRAR <b>Jul 10 1959</b>	
ADDRESS <b>Laurel, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur G. Hays</b>	





TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7595 CERTIFICATE OF DEATH

07570

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>19 Bond Ave.</b>				d. STREET ADDRESS <b>19 Bond Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ERNEST</b> Middle <b>DUTTON</b> Last <b>DUTTON</b>				4. DATE OF DEATH Month <b>July</b> Day <b>24</b> Year <b>59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 19, 1919</b>	
				9. AGE (In years last birthday) yrs. <b>39</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Alfred Dutton</b>				14. MOTHER'S MAIDEN NAME <b>Fannie Little</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Address <b>M's Margaret Dutton 19 Bond Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Decompensation</b> <b>434.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Nephritis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>9 mos.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>none</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>none</b>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>none</b>	
21. I certify that I attended the deceased from <b>3-21-58</b> , 19____, to <b>7-24-59</b> , 19____, that I last saw the deceased alive on <b>7-23-59</b> , 19____, and that death occurred at <b>1 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6 Hanover Rd.</b> DATE SIGNED <b>7-25-59</b>							
ACTUAL SIGNATURE <b>D. D. Caples</b> M.D.				DATE SIGNED <b>7-25-59</b>			
PHYSICIAN'S NAME (Type) <b>D. D. Caples, M. D.</b>				Reisterstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-28-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Luke's Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Reisterstown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mr<sup>s</sup> Frances A. Hemsley</b>				ADDRESS <b>578 W. Biddle St</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 29 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanks</b>			



## Reg. Dist. No.

VS A15 (4)  
15M 10/57



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7597 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

Reg. Dist. No. 07572

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>23 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>2305 Edgemont Avenue (17)</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>B.</b> Last <b>DYSON</b>				4. DATE OF DEATH Month <b>July</b> Day <b>8</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 2, 1893</b>	
9. AGE (In years last birthday) <b>66</b> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Odd jobs</b>		11. BIRTHPLACE (State or foreign country) <b>St. Mary's Co., Maryland</b>	
12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>				13. FATHER'S NAME <b>John J. Dyson</b>			
14. MOTHER'S MAIDEN NAME <b>Emma Jones</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>			
16. SOCIAL SECURITY NO. <b>217-01-4585</b>				17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOGENIC CARCINOMA, RIGHT UPPER LOBE</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>THORACOTOMY, RIGHT July 7, 1959</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month _____ Day _____ Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>June 15</b> , 19 <b>59</b> , to <b>July 8</b> , 19 <b>59</b> , that I last saw the deceased <b>alive on June 15, 1959</b> , and that death occurred at <b>12:02A M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <b>7/8/59</b>							
ACTUAL SIGNATURE <b>Donald D. Mark</b>				M.D. <b>VAH, FORT HOWARD, MARYLAND</b>			
PHYSICIAN'S NAME (Type) <b>DONALD D. MARK, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/11/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Peters Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Bentlow, Laurens, Balto. Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Katie Williams</b> ADDRESS <b>Katie Williams Funeral Home, 322 N. Schroeder St. Baltimore, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton E. F. Lewis</b>	



7598

# CERTIFICATE OF DEATH

07573

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New Jersey</b>		b. COUNTY <b>Camden</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>322 Dixie Drive</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gloucester City</b>		d. STREET ADDRESS <b>320 Mommouth Road</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>322 Dixie Drive</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ELLA May</b>		First Middle Last <b>EDWARDS</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>18</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 22, 1876</b>	9. AGE (In years last birthday) <b>83</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Franklin Jones</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Turner</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Mrs. Raymond Miller, Jr.</b>		Address <b>322 Dixie Drive</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> <b>181.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>AZOTEMIA</b> DUE TO (c) <b>CARCINOMA OF BLADDER</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b> <b>3 MONTHS</b> <b>6 MONTHS</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/15</b> , 19 <b>59</b> , to <b>7/18</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7/18</b> , 19 <b>59</b> , and that death occurred at <b>8:10 P.</b> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Donald L. Somerville</b>		M.D. <b>25 W. Pennsylvania Avenue</b>		ADDRESS (Street, city or town, state) <b>Towson 4 Maryland</b>		DATE SIGNED <b>7/18/59</b>	
PHYSICIAN'S NAME (Type) <b>DONALD L. SOMERVILLE, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 22, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Harleigh</b>		22d. LOCATION (City, town, or county) (State) <b>Camden, New Jersey</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons, Inc.</b>		ADDRESS <b>1900 Eutaw Place</b>		24a. REC'D BY REGISTRAR <b>JUL 23 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur P. Hume</b>	
<b>Baltimore, 17, Maryland</b>							

**TO HOSPITAL:** ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** R: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7546

Item 1 filed 4-7-59

## CERTIFICATE OF DEATH

Reg. Dist. No.

07574

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN 1b <b>Private home.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>5 Winona Ave.</b>		e. STREET ADDRESS <b>300 Wise Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>Sue Virginia Eilerman</b>		4. DATE OF DEATH <b>July 11, 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 26, 1885</b>
9. AGE (In years and birthday) <b>74</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Oxford, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Benjamin Walmsley</b>		14. MOTHER'S MAIDEN NAME <b>Martha Washington</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Mr. Fred Eilerman Sr.</b>		Address <b>300 Wise Ave. Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Congestive heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>5 years</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1955</b> to <b>11 July, 1959</b> , that I last saw the deceased alive on <b>8 July 1959</b> , and that death occurred at <b>11 A. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>B. W. Sokolod, M.D.</b>		DATE SIGNED <b>7-13-59</b>	
PHYSICIAN'S NAME (Type) <b>B. W. Sokolod, M.D.</b>		<b>Dundalk - 222d</b>	
22a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-14-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Gov. Ritchie Hwy. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Duda</b>		ADDRESS <b>7922 Wise Ave. 22, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUL 15 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

VS. A15ME  
5M 2/57

7599

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film 6246 8-3-59 et

07575

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Ma.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>502 Owings Ave.</b>				e. STREET ADDRESS <b>502 Owings Ave.</b>			
3. NAME OF DECEASED (Type or print) <b>Elizabeth</b> First Middle Last <b>Ellis</b>				4. DATE OF DEATH Month <b>July</b> Day <b>27</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 1, 1876</b>	
9. AGE (In years, last birthday) <b>82 yrs.</b>		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>2</b>		11. IF UNDER 24 HRS Hours <b>8</b> Min <b>2</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			
11. BIRTHPLACE (State or foreign country) <b>Pa.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>			
13. FATHER'S NAME <b>George W. Payne</b>				14. MOTHER'S MAIDEN NAME <b>Hally</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>7-12-12</b>			
17. INFORMANT <b>Mr. Robert Ellis - Reisterstown</b>				Address <b>Reisterstown, Balto., Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>none</b> DUE TO (c) <b>none</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fractured left hip</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>none</b>							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Fell in hallway and fractured left hip.</b>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>12-18-58</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>				20f. (City or town) (County) (State) <b>Reisterstown, Balto., Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>D. D. Conles</b>				DATE SIGNED <b>7-28-59</b>			
EXAMINER'S NAME (Type) <b>D. D. Conles, M. D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>7-30-59</b>		<b>Oakland</b>		<b>Reisterstown, Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Haight</b>				24a. REC'D BY REGISTRAR <b>Arthur S. Haight</b>			
ADDRESS <b>Reisterstown, Balto., Md.</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Haight</b>			

DATE SIGNED

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

7-28-59

DATE JUL 29 '59

Arthur S. Haight



TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

7600

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07576

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Granite</b>		c. LENGTH OF STAY IN TB <b>32 yrs.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Granite</b>		X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Davis Avenue</b>		d STREET ADDRESS <b>Davis Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>ELLWOOD</b> Last		4. DATE OF DEATH Month <b>July</b> Day <b>2nd.</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 6, 1869</b>
9. AGE (In years last birthday) <b>89 yrs</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Realy</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Jones</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Anna Birmingham Davis Ave. Granite, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Vabr. Heart Disease</b> <b>4 x 1.4</b> DUE TO <b>and heat prostration</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____ (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 1, 1959</b> to <b>July 2, 1959</b> , that I last saw the deceased alive on <b>July 2, 1959</b> , and that death occurred at <b>Granite, Md.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Wm. E. Martin</b> M.D. <b>Randallston, Md 7/3/59</b> PHYSICIAN'S NAME (Type) <b>W E MARTIN</b>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/6/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Laurel, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Easton Sons</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 7 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>William E. Kline</b>			



7601

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07577

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. LENGTH OF STAY IN TB <u>20 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>15 Maryland Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NORMAN</u> Middle <u>CAROL</u> Last <u>EPPLEY</u>		4. DATE OF DEATH Month <u>July</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 28, 1900</u>
9. AGE (in years last birthday) <u>58</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman, Stebbens</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William H. Eppley</u>	
14. MOTHER'S MAIDEN NAME <u>Mamie L. Reisinger</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>218-09-261</u>		17. INFORMANT Address <u>Edith R. Eppley - 15 Maryland Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Hour <u>none</u> o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>	20f. (City or town) (County) (State) <u>none</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>D. D. Charles</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>D. D. Charles, M. D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>7-11-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-11-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>DRUID RIDGE</u>	22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell, Pikesville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 14 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>

TO DEPUTY / EXAMINER: This certificate should be issued within 24 hours after death. If any delay is necessary, please advise the Registrar. This certificate is valid only if the word "pending" is written in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.





CERTIFICATE OF DEATH

Reg. Dist. No.

07578

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lochearn</b>				c. LENGTH OF STAY IN 1b <b>X Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3620 Oak Avenue</b>				d. STREET ADDRESS <b>3620 Oak Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>META S.</b> Middle <b>FEDERLINE</b> Last				4. DATE OF DEATH Month <b>July</b> Day <b>6</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 7, 1888</b>		9. AGE (In years last birthday) <b>70</b> yrs	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Westminster, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Stonesifer</b>				14. MOTHER'S MAIDEN NAME <b>Annie Barnes</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>ARTHUR P. FEDERLINE</b> Address <b>3620 Oak Avenue</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO <b>Hypertensive, arteriosclerotic</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>cardio-vascular disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>3 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 30, 1956</b> to <b>July 6, 1959</b> , that I last saw the deceased alive on <b>July 6, 1959</b> , and that death occurred at <b>7 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Louis E. Wice</b>				ADDRESS (Street, city or town, state) <b>920 St. Paul St.</b>		DATE SIGNED <b>7/8/59</b>	
PHYSICIAN'S NAME (Type) <b>Louis E. Wice M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 10, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Westminster Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Westminster Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ELLSWORTH ARMAGOST</b>				24c. REC'D BY REGISTRAR DATE <b>JUL 14 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. **02579**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ridgeway Manor Nursing Home</b>		d. STREET ADDRESS <b>4758 Aldgate Green</b>	
3. NAME OF DECEASED (Type or print) First <b>ANDREW</b> Middle <b>G.</b> Last <b>FRANK</b>		4. DATE OF DEATH Month <b>July</b> Day <b>2</b> Year <b>1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 8, 1885</b>
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Adam Hat Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Frank</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Henry J. Frank, son, above</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma Ascending Colon</b> <b>153.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12-16</b> 19 <b>55</b> , to <b>7-2</b> 19 <b>59</b> , that I last saw the deceased alive on <b>7-2</b> 19 <b>59</b> , and that death occurred at <b>9:15 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>1227 Wash. Blvd Baltimore Md 7/3/59</b>			
ACTUAL SIGNATURE <b>John P. Unlock Jr</b> M.D.		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/6/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Schimunek</b>		ADDRESS <b>3331 Brehms Lane</b>	
24a. REC'D BY REGISTRAR <b>JUL 7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Schimunek</b>	



TO DEPUTY LOCAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the body, and forward it to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

7604  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07580

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>414 LORRAINE AVE.</u>		d. STREET ADDRESS <u>414 LORRAINE AVE.</u>	
3. NAME OF DECEASED (Type or print) First <u>ERNEST</u> Middle <u>FRANKLIN</u> Last <u>FRANKLIN</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>11</u> Year <u>19 59</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-9-89</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GLEN L MARTIN (RETIRED)</u>	11. BIRTHPLACE (State or foreign country) <u>England</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>WILLIAM FRANKLIN</u>	
14. MOTHER'S MAIDEN NAME <u>?</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>218-09-4810</u>		17. INFORMANT Address <u>CARRIE FRANKLIN 414 LORRAINE AVE. BALTO. 21</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A-S-E-V-I- DISASE</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) _____		INTERVAL BETWEEN ONSET AND DEATH _____	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>None</u>	
20c. TIME OF INJURY Hour _____ o. m. _____ p. m. _____ Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>1777.350.222</u>		DATE SIGNED <u>7/13/59</u>	
EXAMINER'S NAME (Type) <u>11-13. DAVIS MD</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7-14-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO. CO. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connolly</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 16 '59</u>	
ADDRESS <u>418 Eastern Blvd. 21</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kimes</u>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 07581

7605

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived) II institution Residence before admission a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>1 month</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Maryland</u>		d. STREET ADDRESS <u>8116 Tohoma Drive</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Frymire</u> Last <u>Frymire</u>		4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>19 59</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 30, 1885</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>post office worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Post Office</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Elwood Frymire</u>		14. MOTHER'S MAIDEN NAME <u>Theresa Tuefel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO <u>Unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac fibrillation</u> DUE TO (c) <u>Hypertensive cardiovascular disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 month</u> <u>years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 2</u> , 19 <u>59</u> , to <u>July 2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 2</u> , 19 <u>59</u> , and that death occurred at <u>9:30 a.m.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stella Wachslar</u>		DATE SIGNED <u>7-2-59</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>		<u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/5/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Harmony</u>		22d. LOCATION (City, town, or county) (State) <u>Milton, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Donna Matteson</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 6 '59</u>	
ADDRESS <u>28</u>		24b. REGISTRAR'S SIGNATURE <u>Collier &amp; Kline</u>	





may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7606

CERTIFICATE OF DEATH

07582

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution, Res dence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LUTHERVILLE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RUXTON</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>COLLEGE MANOR</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JESSIE</b> Middle <b>W</b> Last <b>FULTON</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>25</b> Year <b>1959</b>			
5 SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 28, 1884</b>		9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>BERRY WILLIAMS</b>				14. MOTHER'S MAIDEN NAME <b>VIRGINIA FLORIDA GAMMON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service) <b>NONE</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		INFORMANT <b>FAMILY RECORDS</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b> DUE TO <b>443X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Hypertensive cardio vascular disease Aortic Insufficiency</b> DUE TO (c) <b>Arteriosclerosis generalized, post hemiplegia</b>							INTERVAL BETWEEN ONSET AND DEATH <b>72 hours</b> <b>10 years</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary carcinoma</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 22</b> , 19 <b>46</b> , to <b>July 23</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>July 23</b> , 19 <b>59</b> , and that death occurred at <b>9:30 A</b> .M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>18 East Eager Street</b> DATE SIGNED <b>7/27/59</b>							
ACTUAL SIGNATURE <b>[Signature]</b>		M.D. <b>B. H. Rutledge, M. D.</b> <b>Baltimore 2, Maryland</b>					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7/27/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>DRUID RIDGE CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>PIKESVILLE MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN BURNS SONS</b> ADDRESS <b>TOWSON MD.</b>				24a. REC'D BY REGISTRAR <b>JUL 31 '59</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



TO DEPUTY JUDICIAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please extend the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7607 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07583

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>402 Backriver Neck Road</b>				d. STREET ADDRESS <b>402 Backriver Neck Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>B.</b> Last <b>GAFF</b>				4. DATE OF DEATH Month <b>July</b> Day <b>16</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Apr. 27, 1893</b>	
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min. <b>66</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>Balto. Md.</b>	
13. FATHER'S NAME <b>Albert Kutcher</b>				14. MOTHER'S MAIDEN NAME <b>Anna Stepanek</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>John T. Gaff, 402 Back River Neck Rd. Balto. Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Stab wounds of chest</b> <b>782x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Stabbed in chest</b>					
20c. TIME OF INJURY Hour <b>2:00</b> a. m. <b>7/16</b> Month, Day, Year <b>1959</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>House</b>		20f. (City or town) <b>Essex</b> (County) <b>Baltimore</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>William V. Lovitt, Jr.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>7/16/59</b>	
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 20/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Pk.</b>		22d. LOCATION (City, town, or county) (State) <b>Elkridge Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Philip H. Herwig Sons</b>				ADDRESS <b>2024 Orleans St. 31</b>		24a. REC'D BY REGISTRAR <b>DATE JUL 20 '59</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hume</b>	



7608  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

Reg. Dist. No 07584

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Catonville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>✓</u>		d. STREET ADDRESS <u>1652 Ridge Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Marie L. Hardness</u>		4. DATE OF DEATH Month <u>7</u> Day <u>12</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 28/1876</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>	
11. BIRTHPLACE (State or foreign country) <u>Ta.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Daniel Leicht</u>		14. MOTHER'S MAIDEN NAME <u>Dorothea Berentzen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown, (If yes give war or dates of service))		16. SOCIAL SECURITY NO <u>INFORMANT</u> Address <u>Dorothea Leicht Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Ca. RD. Lung</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Primary Ca. Breast</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>67mo</u> <u>377</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>am</u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4-15-1943</u> to <u>7-12-1959</u> , that I last saw the deceased alive on <u>7-10-1959</u> , and that death occurred at <u>9:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u>		ADDRESS (Street, city or town, state) <u>6209 Frederick Ave.</u> DATE SIGNED <u>7-13-59</u>	
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>		<u>Baltimore-28, Md.</u>	
22a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/15/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. H. &amp; Son</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 16 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7609

## CERTIFICATE OF DEATH

Reg. Dist. No.

00585

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville 20</b>		c. LENGTH OF STAY IN 1b <b>4 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Grove State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Grove State Hospital</b>		d. STREET ADDRESS <b>Unknown 1003 St. Albans Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Agnes</b> Middle <b>Giese</b> Last <b>Giese</b>		4. DATE OF DEATH Month <b>July</b> Day <b>20</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1856</b> <b>12- 25- 1856</b>
9. AGE (In years last birthday) <b>102</b>		IF UNDER 1 YEAR Months <b>102</b> Days <b>102</b> Hours <b>102</b> Min <b>102</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>August Sauer</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>XXXXXXXXXX No</b>	
17. INFORMANT <b>Wilmer Brinton Giese, (son)</b>		Address <b>1003 St. Albans Rd Baltimore 12, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO Generalized arteriosclerosis, severe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS A JTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1</b> , 19 <b>59</b> , to <b>July 20</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>July 20</b> , 19 <b>59</b> , and that death occurred at <b>2:50 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE HOSPITAL</b> DATE SIGNED <b>7/20/59</b>			
ACTUAL SIGNATURE <b>PATRICK KI-YUK YIP</b> M.D.			
PHYSICIAN'S NAME (Type) <b>PATRICK KI-YUK YIP</b>		<b>BALTIMORE 29, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/23/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tiekner &amp; Sons</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>DATE JUL 22 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Carl &amp; Kline</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7610

## CERTIFICATE OF DEATH

Reg. Dist. No. 07586

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>2yr6mth20dys</b>		d. STREET ADDRESS <b>Eutaw Place</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Samuel</b> Middle <b>J.</b> Last <b>Gold</b>		4. DATE OF DEATH Month <b>July</b> Day <b>22</b> Year <b>19 59</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 9, 1864</b>
9. AGE (In years last birthday) yrs <b>94</b>		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Abram Gold</b>		14. MOTHER'S MAIDEN NAME <b>Babette Hutzler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 2</b> , 19 <b>57</b> , to <b>July 22</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>July 22</b> , 19 <b>59</b> , and that death occurred at <b>3:40a</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachslar</b>		DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 7-22-59</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/24/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Har Sinai Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Edgewood Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>David R. Martin</b>		24a. REC'D BY REGISTRAR <b>1902 Eutaw Pl</b>	
24b. REGISTRAR'S SIGNATURE <b>Julius E. K...</b>		DATE <b>JUL 27 '59</b>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7611

## CERTIFICATE OF DEATH

Reg. Dist. No. 07587

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE COUNTY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>50 yrs.</u>		d. STREET ADDRESS <u>3914 West Garrison Avenue</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sweet Air Road, Baldwin, Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Mildred</u> Last <u>Gray</u>		4. DATE OF DEATH Month <u>July</u> Day <u>31</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 30, 1899</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wm R. McCloyton Co</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>John McCambridge</u>		14. MOTHER'S MAIDEN NAME <u>Abigail Roche</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-30-4788</u>	
17. INFORMANT <u>FAHNB</u> Address <u>Mrs Mildred A Russo, Sweet Air Road Baldwin Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma 2 metastases</u> DUE TO (b) <u>(Daughter)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 6, 1959</u> , to <u>June 15, 1959</u> , that I last saw the deceased alive on <u>June 15, 1959</u> , and that death occurred at <u>2:50 PM, July 31, 1959</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry L McCorkle</u>		ADDRESS (Street, city or town, state) <u>Jarrettsville Pike</u>	
PHYSICIAN'S NAME (Type) <u>Henry L McCorkle MD</u>		DATE SIGNED <u>7/31/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG-3-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WILLIAM COOK-TOWSON, INC-TOWSON MD</u>		ADDRESS <u>Jarrettsville Pike</u>	
24a. REC'D BY REGISTRAR <u>AUG 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7612

## CERTIFICATE OF DEATH

Reg. Dist. No.

07588

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>14</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. LENGTH OF STAY IN 1b <u>3</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		d. STREET ADDRESS <u>3005 POTTY HILL Ave</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3005 POTTY HILL Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>G LAF</u> Middle <u>GRO</u> Last <u>Febert</u>		4. DATE OF DEATH Month <u>July</u> Day <u>31</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 2 1880</u>
9. AGE (In years last birthday) <u>79</u> yrs		IF UNDER 1 YEAR Months Days Hours M.n	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Paper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>on ship</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HERMAN GROFEbert</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Loebert</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>086-12354</u>	
17. INFORMANT <u>Johanna GROFEbert</u>		Address <u>3005 POTTY HILL Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> <u>SS4X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>10 June</u> 19 <u>59</u> , to <u>31 July</u> 19 <u>59</u> , that I last saw the deceased alive on <u>31 July</u> 19 <u>59</u> , and that death occurred at <u>3:30 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard Goodman</u> M.D.		ADDRESS (Street, city or town, state) <u>B664 Harford Rd Baltimore Md</u>	
PHYSICIAN'S NAME (Type) <u>Howard Goodman</u>		DATE SIGNED <u>1 Aug 59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>Aug 3 - 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT Crematory</u>		22d. LOCATION (City, town, or county) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas F. Evans &amp; Son</u>		ADDRESS <u>8502 HARFORD RD</u>	
24a. REC'D BY REGISTRAR <u>DATE AUG 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7547

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07589

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> c. LENGTH OF STAY IN lb. <b>Dundalk</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7403 Manchester Rd. # 22</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Id.</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> d. STREET ADDRESS <b>7403 Manchester Rd., # 22</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FLORENCE</b> Middle <b>GUNNIP</b> Last <b>GUNNIP</b>		4. DATE OF DEATH Month <b>July</b> Day <b>3</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 24, 1910</b>
9. AGE (In years last birthday) <b>49</b> yrs		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>1</b> Hours <b>1</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shoe Cutter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Oriole Shoe Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>ELIZABETH W. VA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>A. R. JOHNSON</b>		14. MOTHER'S MAIDEN NAME <b>MARY L. GAINER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>----</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>George T. Gunnip</b>		Address <b>Same.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>(b)</b> DUE TO <b>(c)</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>18</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <b>19</b> a. m. <b>p. m.</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Jack C. Collins</b>		DATE SIGNED <b>7-4-59</b>	
EXAMINER'S NAME (Type) <b>Jack C. Collins</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-6-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Balto. MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Zeiler</b>		24. REC'D BY REGISTRAR <b>DATE JUL 7 '59</b>	
ADDRESS <b>901 S. CONKLING ST. BALTO., 24, MD.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hunt</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7613

## CERTIFICATE OF DEATH

Reg. Dist. No.

07590

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD, MARYLAND</b>	c. LENGTH OF STAY IN 1b <b>6 DAYS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>2 BALTIMORE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>6 ROBERTS AVENUE</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ARTHUR</b> Middle <b>A.</b> Last <b>HARDY</b>		4. DATE OF DEATH Month <b>July</b> Day <b>22</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 6, 1913</b>
9. AGE (In years last birthday) <b>46 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electric Truck Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Factory</b>	
11. BIRTHPLACE (State or foreign country) <b>Catonsville, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Hardy</b>		14. MOTHER'S MAIDEN NAME <b>Mary Purver</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO. <b>216-12-9053</b>	
17. INFORMANT <b>Clin. Records, Vet. Adm. Hosp. Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <b>CARDIAC ARRHYTHMIA</b> DUE TO Canditans, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b). <b>ARTERIOSCLEROTIC HYPERTENSIVE CARDIOVASCULAR DISEASE</b> DUE TO (c). INTERVAL BETWEEN ONSET AND DEATH <b>5 MINUTES</b> <b>10 YEARS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>VA</b> attended the deceased from <b>July 16</b> , 19 <b>59</b> , to <b>July 22</b> , 19 <b>59</b> , and that death occurred at <b>4:25 P.M.</b> from the causes and on the date stated above. <b>ADDRESS (Street, city or town, state)</b> <b>DATE SIGNED</b> <b>VAH, Fort Howard, Maryland 7/22/59</b> <b>JOSEPH J. CILLO, M.D. VAH, Fort Howard, Maryland 7/22/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-27-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mrs. Samuel T. Hemsley, 578 W. Biddle St. Balto. Md.</b>		24a. REC'D BY REGISTRAR <b>JUL 29 1959</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles E. Hemsley</b>			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7614

## CERTIFICATE OF DEATH

Reg. Dist. No.

07591

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>14 Holmhurst Ave</u>				d. STREET ADDRESS <u>14 Holmhurst Ave.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Rose</u>		Middle <u>I. H</u>		Last <u>rtlieb</u>		4. DATE OF DEATH Month <u>July</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 4, 1866</u>		9. AGE (In years last birthday) <u>92</u> yrs	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Buckreus</u>				14. MOTHER'S MAIDEN NAME <u>Not Known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Mrs. George Schubert</u> Address <u>14 Holmhurst Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral L BRONCHOPNEUMONIA</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>TERMINAL</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>	
21. I certify that I attended the deceased from <u>July 1</u> , 19 <u>59</u> , to <u>July 6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 6</u> , 19 <u>59</u> , and that death occurred at <u>6:10 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Melvin N. Borden</u>		M.D. <u>5000 Balto Nat'l Pike</u>		ADDRESS (Street, city or town, state) <u>Balto 29, Md</u>		DATE SIGNED <u>7/9/59</u>	
PHYSICIAN'S NAME (Type) <u>Melvin N. BORDEN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 10, 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>		22d. LOCATION (City, town, or county) (State) <u>A. A. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Farley Funeral Home</u>				ADDRESS <u>Catonsville, Md</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 13 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7615

CERTIFICATE OF DEATH

07592

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN 1b <b>CATONSVILLE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>45. SYMINGTON AVE</b>		d. STREET ADDRESS <b>45. SYMINGTON AVE</b>	
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>RANSOM</b> Last <b>HARTMAN</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>3</b> Year <b>1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB 5, 1883</b>
9. AGE (In years last birthday) <b>76</b> yrs		10. IF UNDER 1 YEAR Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min <b>76</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SELF-EMP.</b>	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY <b>MD.</b>	
13. FATHER'S NAME <b>GEORGE F. HARTMAN</b>		14. MOTHER'S MAIDEN NAME <b>ELLEN M. HIGGINS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>NO</b>	
17. INFORMANT <b>George R. Hartman</b>		Address <b>George R. Hartman</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO (b) <b>Nephrosclerosis</b> DUE TO (c) <b>Prostatism - Ca of Prostate</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Months</b> <b>Unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Shocks &amp; Wier</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>6/29</b> , 19 <b>59</b> , to <b>7/3</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7/3</b> , 19 <b>59</b> , and that death occurred at <b>10 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James J. Wilson</b>		M.D. <b>James J. Wilson</b>	
PHYSICIAN'S NAME (Type) <b>James J. Wilson</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-6-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Catholic Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>BALTO. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Foley Funeral Home</b>		ADDRESS <b>Catonville Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUL 9 59</b>		24b. REGISTRAR'S SIGNATURE <b>William E. Hume</b>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7616

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

07593

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>				d. STREET ADDRESS <b>3612 KIMBLE ROAD</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>CARL</b> First <b>MARTIN</b> Middle <b>HASSELHOFF</b> Last				4. DATE OF DEATH <b>JULY</b> Month <b>9</b> Day <b>1959</b> Year			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT 4 1894</b>	9. AGE (In years last b. rthday) <b>64</b> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RACE TRACK</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES HASSELHOFF</b>				14. MOTHER'S MAIDEN NAME <b>MARY SNYDER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-32-8466</b>		17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY TUBERCULOSIS</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)				INTERVAL BETWEEN ONSET AND DEATH <b>34 YEARS</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DIABETES MELLITUS</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>William Newcomer</b> M.D.				Mt. Wilson, Maryland			
PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>				Superintendent			
22a. BURIAL, CREMATON, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/13/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John A. Moran- 3000 E. Baltimore Street</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Christina S. Frank</b>	





7617

CERTIFICATE OF DEATH

07594

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore,</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Arm, Md.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Glen Arm, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Manor Road</b>		d. STREET ADDRESS <b>Manor Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>Bell</b> Last <b>Hay</b>		4. DATE OF DEATH Month <b>July</b> Day <b>2,</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/8/81</b>
9. AGE (In years last birthday) <b>77</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edmund Purdin</b>		14. MOTHER'S MAIDEN NAME <b>Martha Clay</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
INFORMANT <b>Martha Hay, Kommolan</b>		Address <b>Manor Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Previous Cerebral Hemorrhage, 1951</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Partial paralysis left leg, Total paralysis left arm</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1951</b> , 19 to <b>7/2/59</b> , that I last saw the deceased alive on <b>7/2/59</b> , 19, and that death occurred at <b>10.50 P.</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Harold H. Burns</b> M.D.		PHYSICIAN'S NAME (Type) <b>Harold H. Burns, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JULY 15-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>KEMPTOWN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>KEMPTOWN MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lucian K. Falconer</b>		ADDRESS <b>New Market</b>	
24a. REC'D BY REGISTRAR <b>Ag</b>		24b. REGISTRAR'S SIGNATURE <b>Anthony J. K...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7618

Item 12 Film 8244 7/16/59 cap

CERTIFICATE OF DEATH

07595

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rosedale</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rosedale</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5509 Hamilton Ave.</b>		d. STREET ADDRESS <b>5509 Hamilton Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Hedl</b> Last <b>Hedl</b>		4. DATE OF DEATH Month <b>July</b> Day <b>7</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 23, 1870</b>
9. AGE (In years last birthday) <b>88</b> yrs		IF UNDER 1 YEAR Months <b>00</b> Days <b>00</b> Hours <b>00</b> Min <b>00</b>	IF UNDER 24 HRS Hours <b>00</b> Min <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Christina Bruening</b>		Address <b>5509 Hamilton Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO (b) <b>Advanced arteriosclerosis</b> DUE TO (c) <b>Advanced old age</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>emphysema of the lungs</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>6-25-1959</b> to <b>7-7-1959</b> , that I last saw the deceased alive on <b>7-7-1959</b> , and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>8019 Philadelphia Balto. 6, Md.</b> DATE SIGNED <b>7-8-59</b>			
ACTUAL SIGNATURE <b>Dr. John Geldrich</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Doctor John Geldrich</b>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>7-11-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck, Inc.</b>		ADDRESS <b>5305 Harford Rd.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUL 10 59</b>		24b. REGISTRAR'S SIGNATURE <b>Orlino S. Thomas</b>	

MEDICAL CERTIFICATION



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7619

### CERTIFICATE OF DEATH

07596

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If instit. on. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>	
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <b>7907 Ardmore Ave.</b>		d. STREET ADDRESS <b>7907 Ardmore Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Raymond</b> Middle <b>C.</b> Last <b>Hehn Sr.</b>		4. DATE OF DEATH Month <b>July</b> Day <b>17</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-16-1878</b>
9. AGE (In years last birthday) <b>81 yrs</b>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bakery</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown Hehn</b>		14. MOTHER'S MAIDEN NAME <b>Unknown Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>217-09-2395</b>	
17. INFORMANT <b>Mrs. Minnie Hehn</b>		Address <b>7907 Ardmore Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMA OF BLADDER</b> <b>1810</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)			INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March 8, 1955</b> to <b>July 17, 1959</b> that I lost saw the deceased alive on <b>July 17, 1959</b> , and that death occurred at <b>7 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>George Sawyer</b>		ADDRESS (Street, city or town, state) <b>4808 Hartford Rd. Balto 14, Md.</b>	
PHYSICIAN'S NAME (Type) <b>GEORGE SAWYER - M.D.</b>		DATE SIGNED <b>7/18/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-20-1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Park</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lassahn Funeral Home</b>		ADDRESS <b>7401 Belair Rd.</b>	
24a. REC'D BY REGISTRAR <b>DATE JUL 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	



7620

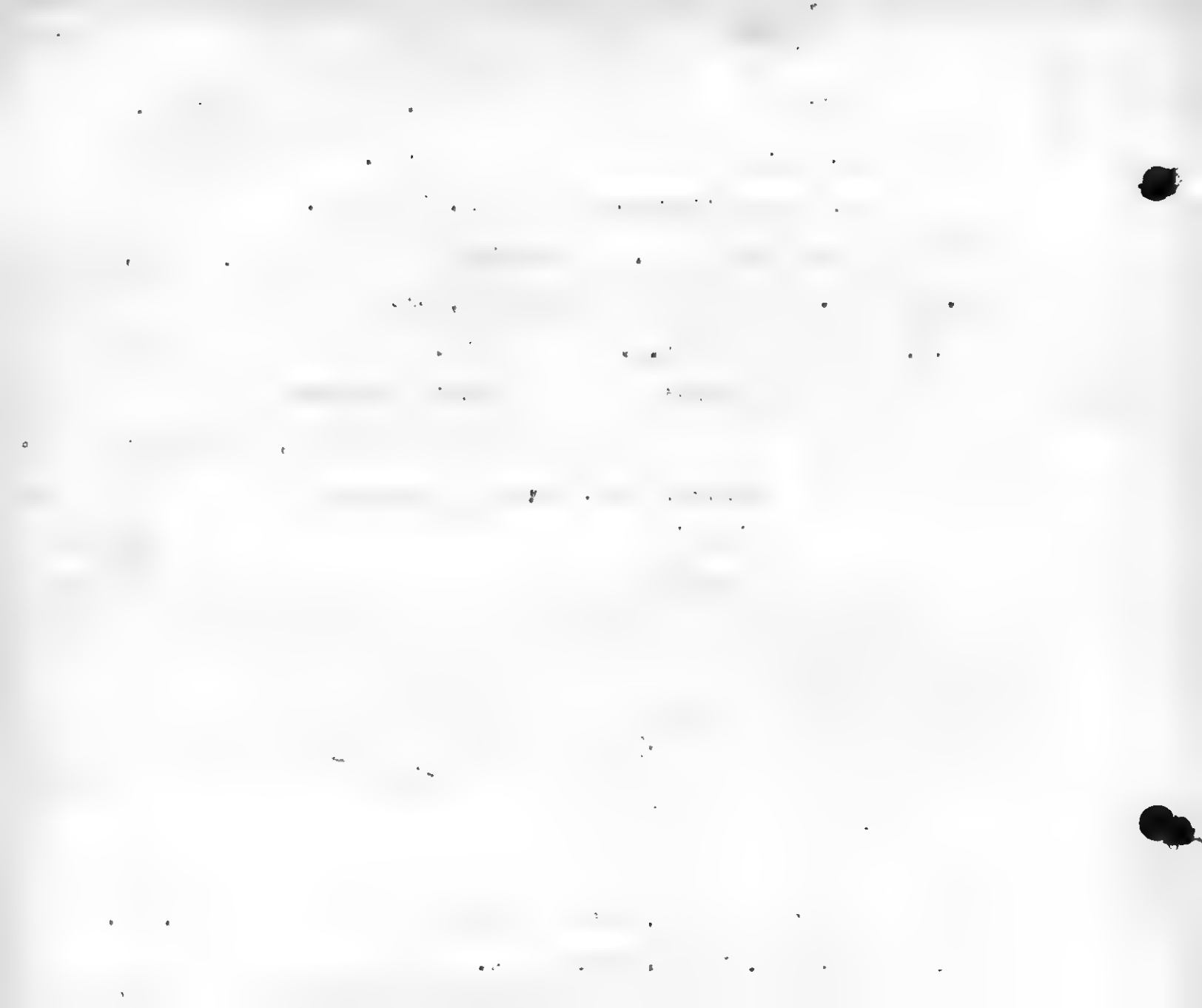
## CERTIFICATE OF DEATH

Reg Dist No

07597

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balto.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Paradise Nursing Home</b>				d. STREET ADDRESS <b>219 S.Hilton St.</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Margaret K. Hendricks</b>				4. DATE OF DEATH Month Day Year <b>July 30, 19 59</b>			
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>July 7, 1893</b>	9. AGE (In years last birthday) <b>66</b> yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>O.H.</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Filkoski</b>				14. MOTHER'S MAIDEN NAME <b>Minnie Hartmann</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Address <b>Mrs Margaret Dulaney, 1602 Inverness Ave</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic Pneumonia</b>							<b>24 hours</b>
DUE TO <b>CVA</b> (b)							<b>96 hours</b>
DUE TO <b>HCV D</b> (c)							<b>10 years</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Jan 10, 1953</b> to <b>July 30, 1959</b> that I last saw the deceased alive on <b>July 30, 1959</b> and that death occurred at <b>219 S. Hilton St.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James R. Gribble</b> M D				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/3/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Dorsey A A Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Witzke Funeral Dir. 4101 Edmondson Ave.</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 4 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7621

## CERTIFICATE OF DEATH

Reg. Dist. No.

07598

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>52</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		d. STREET ADDRESS <b>1104 Baker Ave.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1104 Baker Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Martin</b> Middle <b>Henigman</b> Last <b>Henigman</b>		4. DATE OF DEATH Month <b>July</b> Day <b>6</b> Year <b>1959</b>	
5 SEX <b>M</b>	6 COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 5, 1873</b>
9 AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months <b>85</b> Days <b>85</b> Hours <b>85</b> Min <b>85</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bricklayer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>AUSTRIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank Henigman</b>		14. MOTHER'S MAIDEN NAME <b>Not Known</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>215-05-9871</b>	
17. INFORMANT <b>Rudolph Henigman</b>		Address <b>1104 Baker Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> X DUE TO <b>Cerebral Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>?</b> DUE TO (c) <b>?</b>		INTERVAL BETWEEN ONSET AND DEATH <b>one week</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>?</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March</b> , 1957, to <b>July 6</b> , 1959, that I last saw the deceased alive on <b>July 1</b> , 1959, and that death occurred at <b>8 P.</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1047 Ingleside Ave Baltimore, 28, Md.</b> DATE SIGNED <b>Jul 13 '59</b>			
ACTUAL SIGNATURE <b>Max J. Miller, M.D.</b>		M.D. <b>1047 Ingleside Ave Baltimore, 28, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Max J. Miller, M.D.</b>		M.D. <b>1047 Ingleside Ave Baltimore, 28, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 9, 59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Farley Funeral Home</b>		ADDRESS <b>Catonsville Md.</b>	
24a. REC'D BY REGISTRAR <b>Jul 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7622

## CERTIFICATE OF DEATH

Reg. Dist. No.

07599

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO. 24 MD.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7503 Riddel Ave.</u>				d. STREET ADDRESS <u>7503 RIDDEL AVE.</u>			
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>J</u> Last <u>HETZLER</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>4</u> Year <u>1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 9-1869</u>	
9. AGE (In years last birthday) <u>89 yrs.</u>		IF UNDER 1 YEAR Months <u>89</u> Days <u>89</u> Hours <u>89</u> Min <u>89</u>		IF UNDER 24 HRS. Months <u>89</u> Days <u>89</u> Hours <u>89</u> Min <u>89</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER (BALTO. 4)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BALTO.</u>		11 BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>MATTHEW HETZLER</u>				14 MOTHER'S MAIDEN NAME <u>KATHA HILDEBRANDT</u>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16 SOCIAL SECURITY NO. <u>WM. HETZLER</u>		17 INFORMANT <u>7503 RIDDEL AVE.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic Vascular Disease</u> DUE TO (c) <u>104 years</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>19</u> Hour <u>19</u> a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1010 North Point Road</u>	
20f. (City or town) <u>Baltimore 24 Md.</u>				20g. (County) (State)			
21. I certify that I attended the deceased from <u>April 14, 1959</u> , to <u>July 4, 1959</u> , that I last saw the deceased alive on <u>July 4, 1959</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Morris A. Jacobs</u>				DATE SIGNED <u>7/6/59</u>			
PHYSICIAN'S NAME (Type) <u>MORRIS A. JACOBS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-7-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		22d. LOCATION (City, town or county) (State) <u>Balto. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John L. Connelly</u>				ADDRESS <u>418 Eastern Blvd.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 8 59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>							



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7623

## CERTIFICATE OF DEATH

Reg. Dist. No. **07600**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills, Maryland</b>		c. LENGTH OF STAY IN 1b <b>1 1/2 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosewood State Training School</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Billy</b> Middle <b>Dean</b> Last <b>Hicks</b>		4. DATE OF DEATH Month <b>July</b> Day <b>16</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/20/51</b>
9. AGE (In years last birthday) yrs. <b>8</b>		10. IF UNDER 1 YEAR: Months <b>8</b> Days <b>16</b> Hours <b>16</b> Min <b>16</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		<b>Virginia</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ray Robb Hicks</b>		14. MOTHER'S MAIDEN NAME <b>Gracie Triplett</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Rosewood Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Aspiration of stomach content</b>			
DUE TO <b>Reticuloendotheliosis</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Birth</b>			
(c) <b>Birth</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 1957</b> to <b>July 1959</b> that I last saw the deceased alive on <b>July 16, 1959</b> , and that death occurred at <b>6:10 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Peter W. Rieckert</b>		ADDRESS (Street, city or town, state) <b>4307 Mainfield Ave Baltimore 14</b>	
PHYSICIAN'S NAME (Type) <b>P.W. Rieckert</b>		DATE SIGNED <b>7-16-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>July 20 59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rosewood Cem</b>	22d. LOCATION (City, town, or county) (State) <b>Owings Mills Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Elmer &amp; Sons</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 22 '59</b>	
ADDRESS <b>Reisterstown Md</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the death certificate from the hospital or funeral home and file it with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7624 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07601

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTO.</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u> c. LENGTH OF STAY IN IB d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>27 B GLENWOOD RD.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 ESSEX</u> d. STREET ADDRESS <u>27 B GLENWOOD RD.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>MARGARET</u> <u>M</u> <u>HICKS</u> First Middle Last		<b>4. DATE OF DEATH</b> <u>JULY</u> <u>7</u> <u>1959</u> Month Day Year		<b>5. SEX</b> <u>FEMALE</u> <b>6. COLOR OR RACE</b> <u>WHITE</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>2-27-10</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>49</u> yrs.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>WELDER (MARTIN)</u> <b>13. FATHER'S NAME</b> <u>WALTER KING</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>11. BIRTHPLACE</b> (State or foreign country) <u>NASHVILLE, TENN.</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>ELIZABETH THOMAS</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service) <b>16. SOCIAL SECURITY NO.</b> <u>41-16-0260</u>		<b>17. INFORMANT</b> <u>MARIE SMITH</u> Address <u>504 RIVERSIDE RD.</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Concussion</u> DUE TO <u>Coelusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>							
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>Jack P. Pollin</u>		<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b> <u>7-8-59</u>			
<b>EXAMINER'S NAME (Type)</b> <u>Jack P. Pollin</u>		<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>7-11-59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>SPRING HILL</u>			
<b>22d. LOCATION</b> (City, town, or county) <u>NASHVILLE</u>		<b>(State)</b> <u>TENN.</u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John J. Connelly</u> Address <u>418 Eastern Blvd.</u>			
<b>24a. REC'D BY REGISTRAR</b> <u>DATE JUL 10 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Orthur S. Hurd</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate. Write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

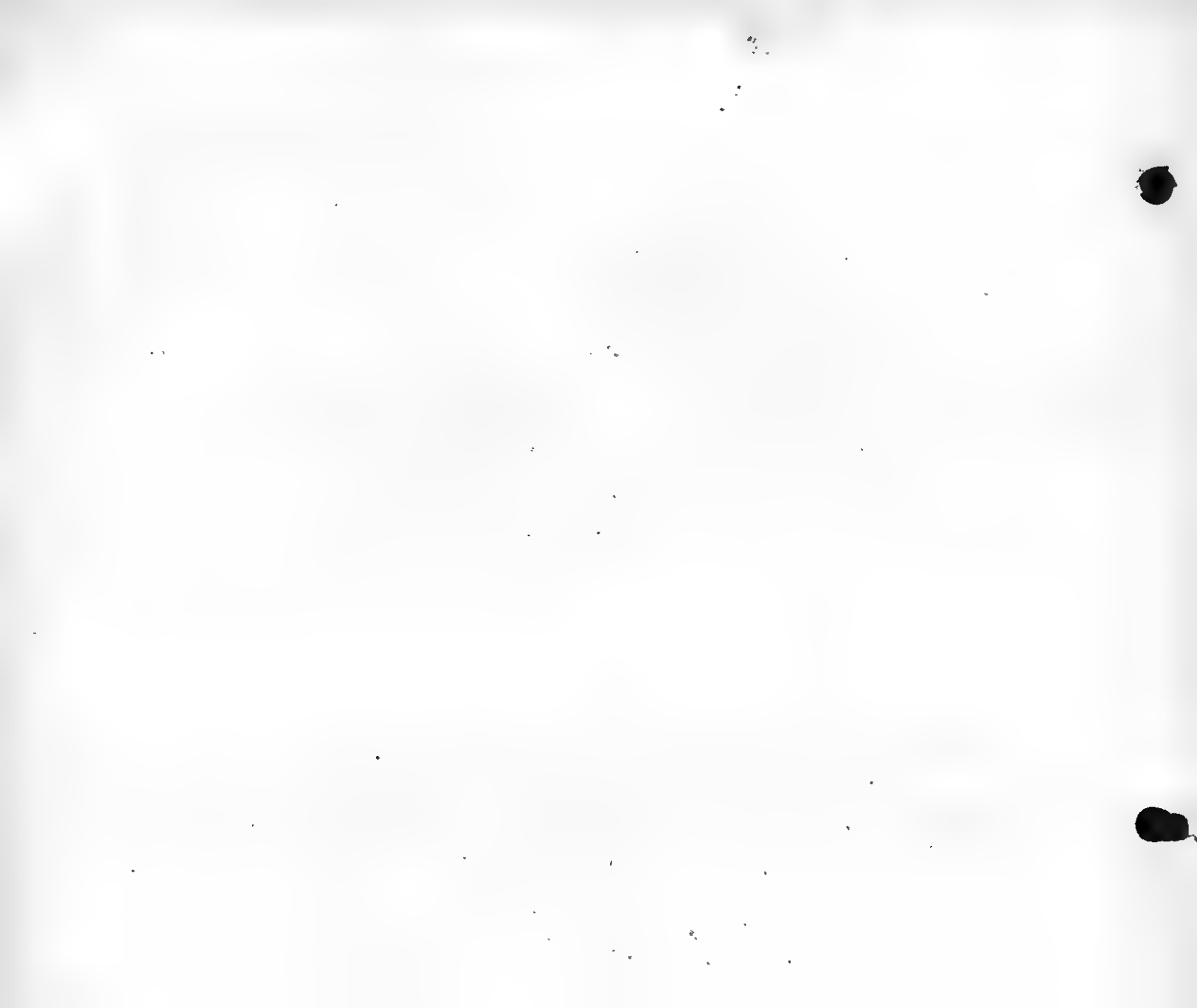
## 7625

## CERTIFICATE OF DEATH

Reg. Dist. No. **07602**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Baltimore</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville 8, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>11 Village Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Mary Durham Hobbs</u>				<b>4. DATE OF DEATH</b> Month <u>July</u> Day <u>19</u> Year <u>1959</u>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>July 23, 1879</u>	
<b>9. AGE</b> (In years last birthday) <u>79</u> yrs.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>William James Durham</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Edith Harriet Deacon</u>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>	
<b>16. SOCIAL SECURITY NO.</b> <u>Dr. Donald Hobbs,</u>		<b>17. INFORMANT</b> <u>Dr. Donald Hobbs,</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Art. Sclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>24 yrs.</u> <u>54 yrs.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18) _____			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. _____ p. m. _____ 19____		<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____		<b>20f. (City or town)</b> _____ (County) _____ (State) _____	
<b>21. I certify that I attended the deceased from</b> <u>JUNE</u> , 19 <u>50</u> , to <u>JULY 19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>JULY 18</u> , 19 <u>59</u> , and that death occurred at <u>4:30 P.M.</u> , from the causes and on the date stated above.							
<b>ACTUAL SIGNATURE</b> <u>James A. Miller, M.D.</u>				<b>ADDRESS</b> (Street, city or town, state) <u>Pikesville, Md.</u>			
<b>PHYSICIAN'S NAME</b> (Type) <u>James A. Miller, M.D.</u>				<b>DATE SIGNED</b> <u>7/24/59</u>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>July 22, 1959</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Olive Cemetery</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Randallstown, Md.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Frank H. Newell, Pikesville 8, Md.</u>				<b>24a. REC'D BY REGISTRAR</b> <u>JUL 22 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kneel</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.



TO HOSPITAL: This certificate may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 4

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7548

# CERTIFICATE OF DEATH

Reg. Dist. No.

07603

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk 22</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6771 Woodley Road</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>53 Dundalk 22</b> d. STREET ADDRESS <b>6771 Woodley Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MALCOLM WOODROW HOLBROOK</b>		4. DATE OF DEATH Month Day Year <b>July 13th, 1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 25, 1917</b>
9. AGE (In years last birthday) <b>42</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>First Helper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Charles J. Holbrook</b>	
14. MOTHER'S MAIDEN NAME <b>Margaret Ingle</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <b>yes 1/3/34-3/37</b>	
16. SOCIAL SECURITY NO. <b>218-05-6861</b>		17. INFORMANT Address <b>Marjorie G. Holbrook same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic CA</b> <b>162.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>17 Months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-5</b> 19 <b>56</b> , to <b>7-13</b> 19 <b>59</b> , that I last saw the deceased alive on <b>7-13</b> 19 <b>59</b> , and that death occurred at <b>8:30</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>2 Kinship Road 7/15/59</b>			
ACTUAL SIGNATURE <b>Jack C. Collins</b> M.D.		2. Kinship Road 7/15/59	
PHYSICIAN'S NAME (Type) <b>Jack C. Collins, M.D.</b>		<b>Baltimore 22, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/17/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Memorial</b>	22d. LOCATION (City, town, or county) (State) <b>Dorsey, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradley, Inc. Dundalk 22</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 17 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur J. Hand</b>			



7626.

## CERTIFICATE OF DEATH

Reg. Dist. No.

07604

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>				c. LENGTH OF STAY IN 1b <u>54</u> <u>Essex</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2107 Boundry Ave.</u>				d. STREET ADDRESS <u>1 2107 Boundry Ave.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Anita Elaine Marie Hollick</u>				4. DATE OF DEATH Month Day Year <u>July 1, 1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-5-59</u>		9. AGE (In years last birthday) yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Vincent C. Hollick</u>				14. MOTHER'S MAIDEN NAME <u>Viola Parrish</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO		17. INFORMANT <u>Vincent Hollick</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital Heart Disease</u> <u>154.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe Mongolism</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1-5</u> , 19 <u>59</u> , to <u>7-1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6-30</u> , 19 <u>59</u> , and that death occurred at <u>1:25 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Max R. English</u> M.D.				ADDRESS (Street, city or town, state) <u>5713 Belair Rd.</u>		DATE SIGNED <u>7-2-59</u>	
PHYSICIAN'S NAME (Type) <u>MAX R. English M.D.</u>				<u>Baito 6 Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/3/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith</u>		22d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>				ADDRESS <u>5305 Harford Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 6 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>William S. Brown</u>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE HEALTH DEPT.**

7627

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. **07605**

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>County</b> <b>MD</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Beth Steel Dispensary</b>				e. STREET ADDRESS <b>8020 Eastern Ave.</b>			
3. NAME OF DECEASED (Type or print) (First Middle Last) <b>(WILBERT) Wilbert T. Holt</b>				4. DATE OF DEATH Month <b>7</b> Day <b>10</b> Year <b>1959</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAR. 26, 1907</b>	
9. AGE (In years last birthday) <b>52 yrs</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Police</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO. CO., MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>America</b>	
13. FATHER'S NAME <b>JAMES A. HOLT</b>				14. MOTHER'S MAIDEN NAME <b>AMELIA EDLER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO <b>NO</b>		17. INFORMANT Address <b>ALFRED J. HOLT 568 WELBROOK RD. #2 MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>NO</b>			
20c. TIME OF INJURY Hour <b>19</b> a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>M B Davis</b>				DATE SIGNED <b>7-10-59</b>			
EXAMINER'S NAME (Type) <b>M. B. Davis, M. D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7-13-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>7225 EASTERN AVE. BALTO. MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Gailer</b>				24a. REC'D BY REGISTRAR <b>JUL 14 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2 57





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7628 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07606

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY _____	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>		c. LENGTH OF STAY IN 1b <u>16 YEARS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3013 Edgewood Ave</u>		e. STREET ADDRESS <u>13013 Edgewood Ave</u>	
3. NAME OF DECEASED (Type or print) <u>ELIZABETH K. HORNE</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>22</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>12</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-27-1881</u>
9. AGE (In years last birthday) <u>77</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LAUNDRY</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ANTHONY F Kiggins</u>		14. MOTHER'S MAIDEN NAME <u>MARY F O'NEAL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-03-554</u>	
17. INFORMANT <u>Mrs Joseph Pazourek</u>		Address <u>2704 Robert Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO (b) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Diabetes Mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs</u> <u>4 yrs</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles F. Evans</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED _____	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JULY 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S</u>	22d. LOCATION (City, town, or county) (State) <u>PARKVILLE Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHAS. F. EVANS + SON</u>		24a. REC'D BY REGISTRAR <u>8802 HARFORD RD.</u>	
24b. REGISTRAR'S SIGNATURE <u>Wm. S. Kraus</u>		DATE <u>JUL 27 '59</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMG. Page 5 may be retained by you after TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7629

CERTIFICATE OF DEATH

Reg. Dist. No.

07607

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>315 Ingleside Ave. Forest Haven Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LILLIE</b> Middle <b>MAY</b> Last <b>HOUFF</b>				4. DATE OF DEATH Month <b>July</b> Day <b>15</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 10, 1876</b>	9. AGE (In years lost birthday) <b>83</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		
13. FATHER'S NAME <b>Joseph Barlow</b>			14. MOTHER'S MAIDEN NAME <b>Catherine Martin</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>none</b>		17. INFORMANT <b>Mrs. J. Carroll Jenkins - 34 Church Rd. / Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>A MYOCARDIAL ISCHEMIC DISEASE</b> DUE TO (c) <b>CARDIAC DISSEASE</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)			20g. (County)		20h. (State)		
21. I certify that I attended the deceased from <b>7/11</b> , 19 <b>59</b> , to <b>7/15</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7/15</b> , 19 <b>59</b> , and that death occurred at <b>2 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5800 E. MARYLAND AVE. BALTO. MD.</b> DATE SIGNED <b>7/15/59</b>							
ACTUAL SIGNATURE <b>John H. Shaw</b>			M.D. <b>JOHN H. SHAW M.D.</b>				
PHYSICIAN'S NAME (Type) <b>JOHN H. SHAW M.D.</b>			<b>BALTO. MD.</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/17/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Bohner</b>				ADDRESS <b>4101 Y. Bohner Y. Bohner Baltimore</b>		24a. REC'D BY REGISTRAR <b>JUL 17 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Orin S. Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7630

## CERTIFICATE OF DEATH

07608

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>				c. LENGTH OF STAY IN 1b <b>life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Warren Rd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <b>Pearl Tracey Howard</b>				4 DATE OF DEATH Month Day Year <b>7-7 1959</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-6-1880</b>	
9. AGE (In years last birthday) <b>79</b> yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (State or foreign country) <b>Penn.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Samuel Tracey</b>				14. MOTHER'S MAIDEN NAME <b>Mary Grimm</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Maurice C. Howard, 404 Danville Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>450.0</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Cockeysville</b>				20g. (County) <b>Harford</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>6 July 1959</b> to <b>7 July 1959</b> , that I last saw the deceased alive on <b>6 July 1959</b> and that death occurred on <b>7 July 1959</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cockeysville Md 7 July 1959</b> DATE SIGNED ACTUAL SIGNATURE <b>Walter T. Kirk</b> M.D. PHYSICIAN'S NAME (Type) <b>WALTER T. KIRK</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-10-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Poplar Grove</b>		22d. LOCATION (City, town, or county) (State) <b>Cockeysville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service, Towson 4, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 10 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

MEDICAL CERTIFICATION

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7631

## CERTIFICATE OF DEATH

Reg. Dist. No. 07609

1 PLACE OF DEATH a. COUNTY <b>BALTO.</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HOUSE INTINES</b>		d. STREET ADDRESS <b>6111 MT. RIDGE RD.</b>	
3. NAME OF DECEASED (Type or print) <b>FIRST MIDDLE LAST</b> <b>JOSEPHINE -HUEGELMEYER</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>31</b> Year <b>1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 9, 1890</b>
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEKEEPER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>WARD</b>		14. MOTHER'S MAIDEN NAME <b>NOT KNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO <input type="checkbox"/>	
17. INFORMANT <b>Walter H. Huegelmeier</b>		Address <b>6111 Mt Ridge Rd</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>551X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Hemorrhage</b> (c) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 hr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>9 am</b> <b>July 25, 1959</b> to <b>July 31, 1959</b> that I last saw the deceased alive on <b>July 25, 1959</b> and that death occurred at <b>5:30 PM</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>2145 W Baltimore Md</b> DATE SIGNED <b>8/1/59</b>			
SIGNATURE <b>Charles A. Cahn</b> M.D.		PHYSICIAN'S NAME (Type) <b>Charles A. Cahn</b>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Buried</b>	<b>8-3-59</b>	<b>Holy Redeemer Ch.</b>	<b>Balto. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter H. Huegelmeier</b>		24. REC'D BY REGISTRAR DATE <b>AUG 4 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.





## 7632 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07610

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u> c. LENGTH OF STAY IN 1b <u>8</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Foxleigh Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville 8</u> d. STREET ADDRESS <u>Grey Rock</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harold</u> Middle <u>Jacobs</u> Last <u>Jacobs</u>		4. DATE OF DEATH Month <u>July</u> Day <u>21</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 28, 1890</u>
9. AGE (in years last birthday) <u>69</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Paw Paw, Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Jacobs</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Wilcox</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>9040</u>	
17. INFORMANT <u>Ethel Epstein Jacobs</u>		Address <u>Grey Rock, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fat emboli, multiple</u> DUE TO (b) <u>Fractured hip</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last: <u>Arteriosclerosis, generalized</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mo. 3 wks.</u> <u>3 mo. 2 wks. &amp;</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <u>Fell in bedroom and fractured hip.</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>Mar. 28</u> p.m. <u>59</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>	20f. (City or town) (County) (State) <u>Pikesville 8, Balto., Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>D. D. Caples</u>		DATE SIGNED <u>7-22-59</u>	
EXAMINER'S NAME (Type) <u>D. D. Caples, M. D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>7-23-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Linden Park</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewin</u>		24a. REC'D BY REGISTRAR <u>JUL 23 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



Reg. Dist. No. 07611

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills, Md.</b>		b. COUNTY	
c. LENGTH OF STAY IN TB <b>6 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 31</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rosewood State Training School</b>		d. STREET ADDRESS <b>242 S. Durham St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Paul Thomas Janicki</b>		4. DATE OF DEATH Month <b>July</b> Day <b>14</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-7-41</b>
9. AGE (In years last birthday) <b>17 yrs</b>		10. IF UNDER 1 YEAR Months <b>17</b> Days <b>14</b> Hours <b>19</b> M n <b>59</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		12. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
13. FATHER'S NAME <b>Casimir Janicki</b>		14. MOTHER'S MAIDEN NAME <b>Pauline Novak</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>none</b>	
17. INFORMANT <b>Rosewood St. Tr. Sc. Records, Owings Mills</b>		18. ADDRESS <b>Md.</b>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Convulsive Seizure</b> <b>780.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>780.2</b> (a), stating the underlying cause last (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Fell off bench backwards &amp; struck head.</b>	
21c. TIME OF INJURY Hour <b>6:30</b> a. m. <b>7-14-59</b>	21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rosewood Sch.</b>	21f. (City or town) <b>Owings Mills, Balto., Md.</b>
21g. (County) <b>Baltimore</b>			
21h. (State) <b>Md.</b>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>C. E. McWilliams M.D.</b>		DATE SIGNED <b>7-15-59</b>	
EXAMINER'S NAME (Type) <b>C. E. McWilliams, M. D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL OR CREMATION REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>JULY 18 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>HOLY ROSARY CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>GERMAN HILL RD MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ruppel Bros. 1800 E LOMBARD ST.</b>		24a. REGD. BY REGISTRAR <b>JUL 17 1959</b>	
ADDRESS <b>1800 E LOMBARD ST.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

**ALL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay occurs, the cause, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**CO DEPUTY:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57



7634 CERTIFICATE OF DEATH

Reg. Dist. No. 07612

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgemere (19)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgemere (19)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6802 River Drive Road</b>		d. STREET ADDRESS <b>6802 River Drive Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>EMIL</b> Middle <b>++++</b> Last <b>JARVINEN</b>		4. DATE OF DEATH Month <b>July</b> Day <b>25th</b> Year <b>1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 24, 1895</b>
9. AGE (In years last birthday) yrs. <b>64</b>		IF UNDER 1 YEAR: Months <b>6</b> Days <b>4</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Heater</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>	
11. BIRTHPLACE (State or foreign country) <b>Finland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Moses Jarvinen</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-07-3994</b>	
17. INFORMANT <b>Arne A. Jarvinen</b>		Address <b>45 Waterview Road Baltimore 22, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Feb.</b> 19 <b>59</b> to <b>July</b> 19 <b>59</b> , that I last saw the deceased alive on <b>June 28</b> , 19 <b>59</b> , and that death occurred at <b>6:30 p.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1313 Darmouth Road</b> DATE SIGNED _____ ACTUAL SIGNATURE <b>W. K. Wong</b> M.D. _____ PHYSICIAN'S NAME (Type) <b>Wyman K. Wong, M.D.</b> <b>Baltimore 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/28/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Co., Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradley, Inc.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 29 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Charles E. Howard</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



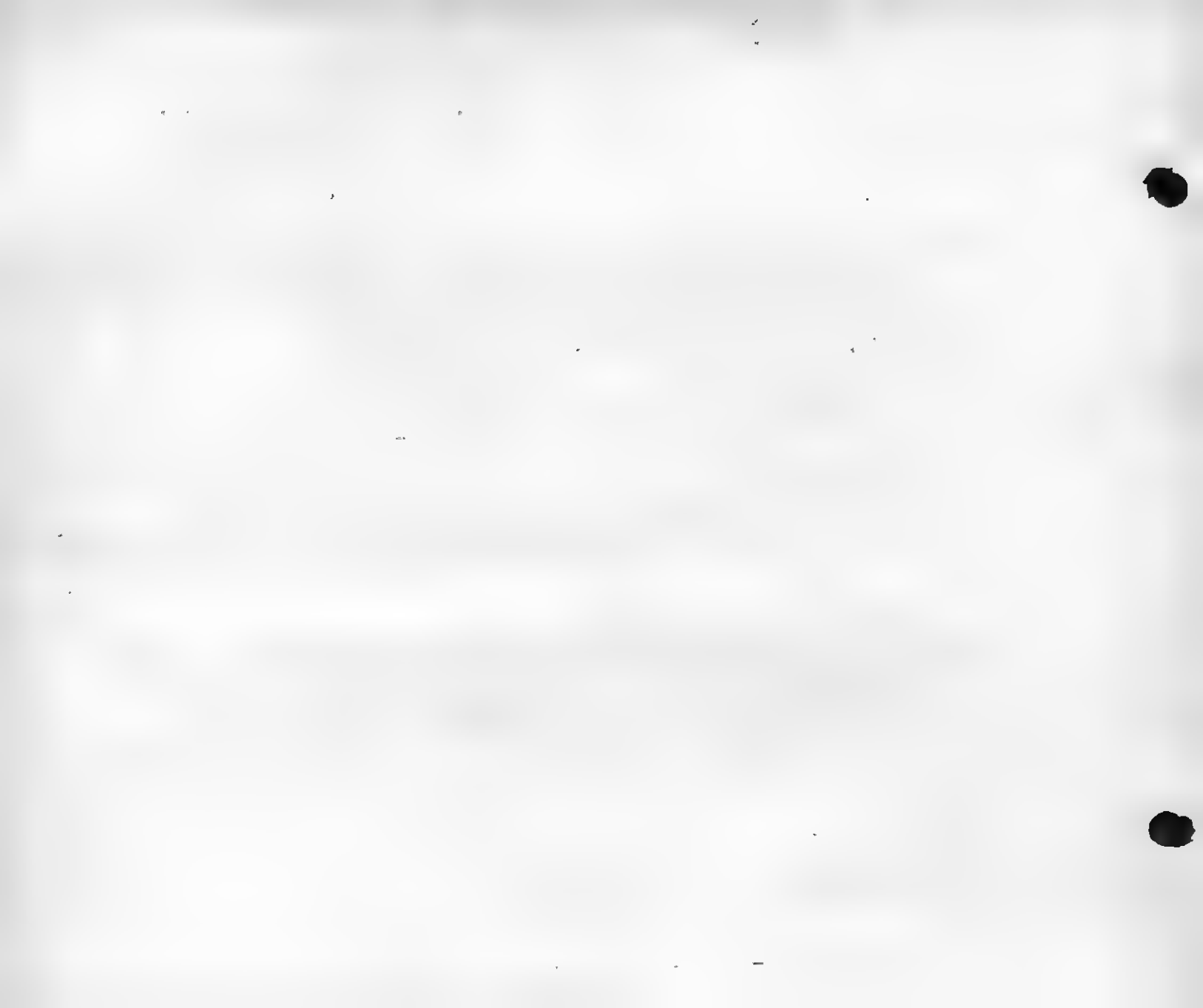
TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15M 10/57

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BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7635  
CERTIFICATE OF DEATH

Reg. Dist. No. 07613

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>A.A.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SOLLEY</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SUMMIT NURSING HOME</b>		d. STREET ADDRESS <b>7110 MARLEY NECK ROAD</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOHN R. JONES</b>		4. DATE OF DEATH Month Day Year <b>7/28/59 July 28 19 59</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/22/73</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MARINE CAP'T.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ARUNDEL CORP.,</b>	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown, (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>FAMILY - SAME</b>	
17. INFORMANT <b>FAMILY - SAME</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardio-vascular disease</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 19, 1959</b> to <b>July 27, 1959</b> , that I last saw the deceased alive on <b>July 26, 1959</b> , and that death occurred at <b>10:45 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>203 Gallop Lane</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Samuel Rubin M.D.</b>		PHYSICIAN'S NAME (Type) <b>SAMUEL RUBIN M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>B</b>		22b. DATE THEREOF <b>8/1/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>MCCULLY FUNERAL HOMES - 130 E. FORT AVE.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 3 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			





7636

## CERTIFICATE OF DEATH

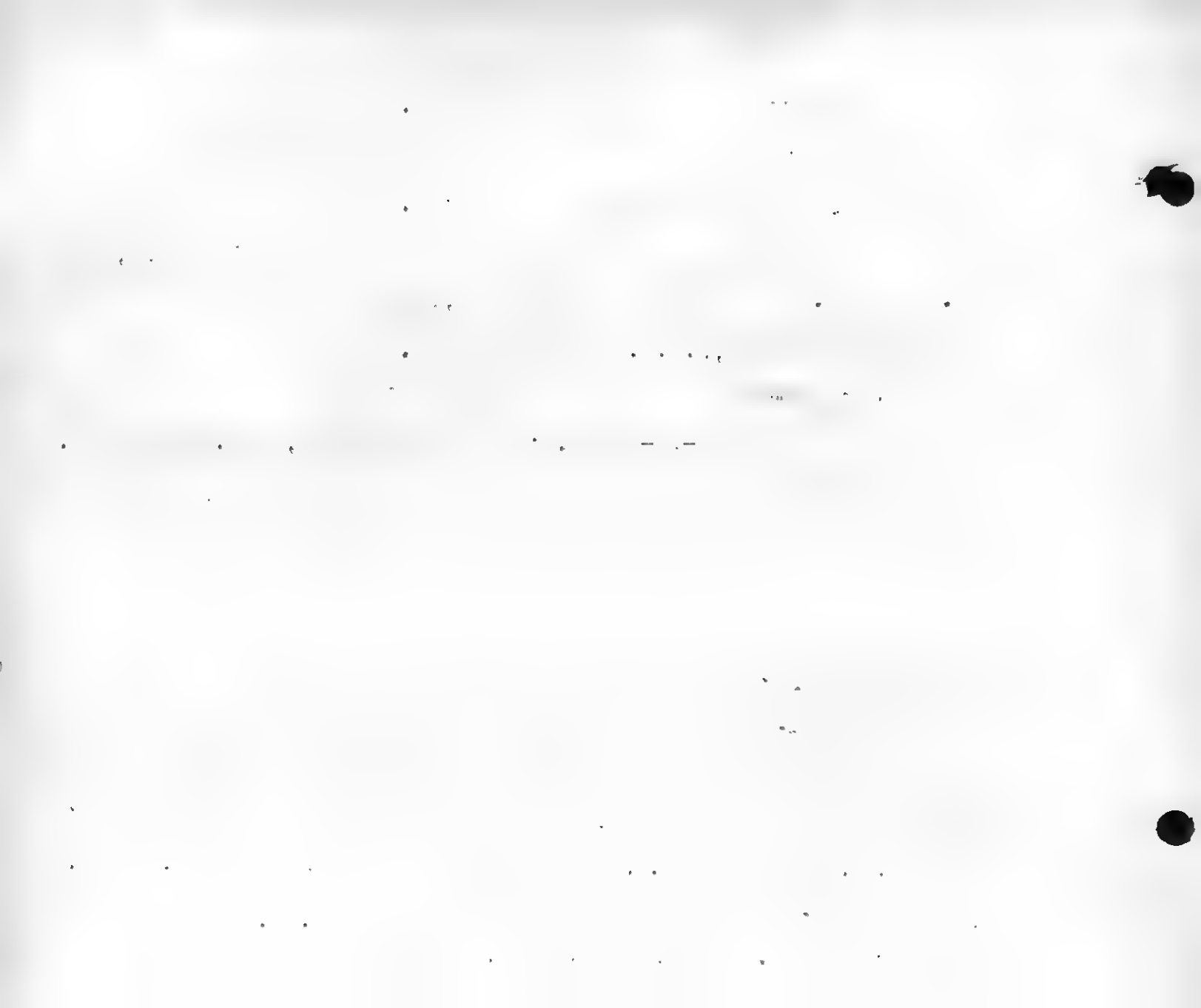
Reg. Dist. No.

07614

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <b>Md.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Shady Nook Nursing Home</b>				d. STREET ADDRESS <b>11 S. Pulaski St</b>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Kammer</b> Last				4. DATE OF DEATH Month <b>July</b> Day <b>31</b> Year <b>1959</b>			
5. SEX <b>M.</b>		6. COLOR OR RACE <b>W.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 27, 1876</b>	
9. AGE (In years last birthday) <b>83</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Maintenance, B.V.D. Underwear</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Md.</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>John Kammer</b>				14. MOTHER'S MAIDEN NAME <b>Marie Sachs</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>212-10-4518A</b>			
17. INFORMANT <b>Miss Sophie Kammer</b>				Address <b>11 S. Pulaski St.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio-vascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypostatic pneumonia</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>March 1954</b> to <b>July 31, 1959</b> that I last saw the deceased alive on <b>July 30, 1959</b> , and that death occurred at <b>4:00</b> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Dennis Laughlin</b> M.D.				ADDRESS (Street, city or town, state) <b>4508 Edmondson Village, Balto. 29, Md.</b>			
DATE SIGNED <b>8/1/59</b>							
PHYSICIAN'S NAME (Type) <b>D. C. MacLaughlin, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/3/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Dir. 4101 Edmondson Ave.</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 4 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**7637**  
**CERTIFICATE OF DEATH**

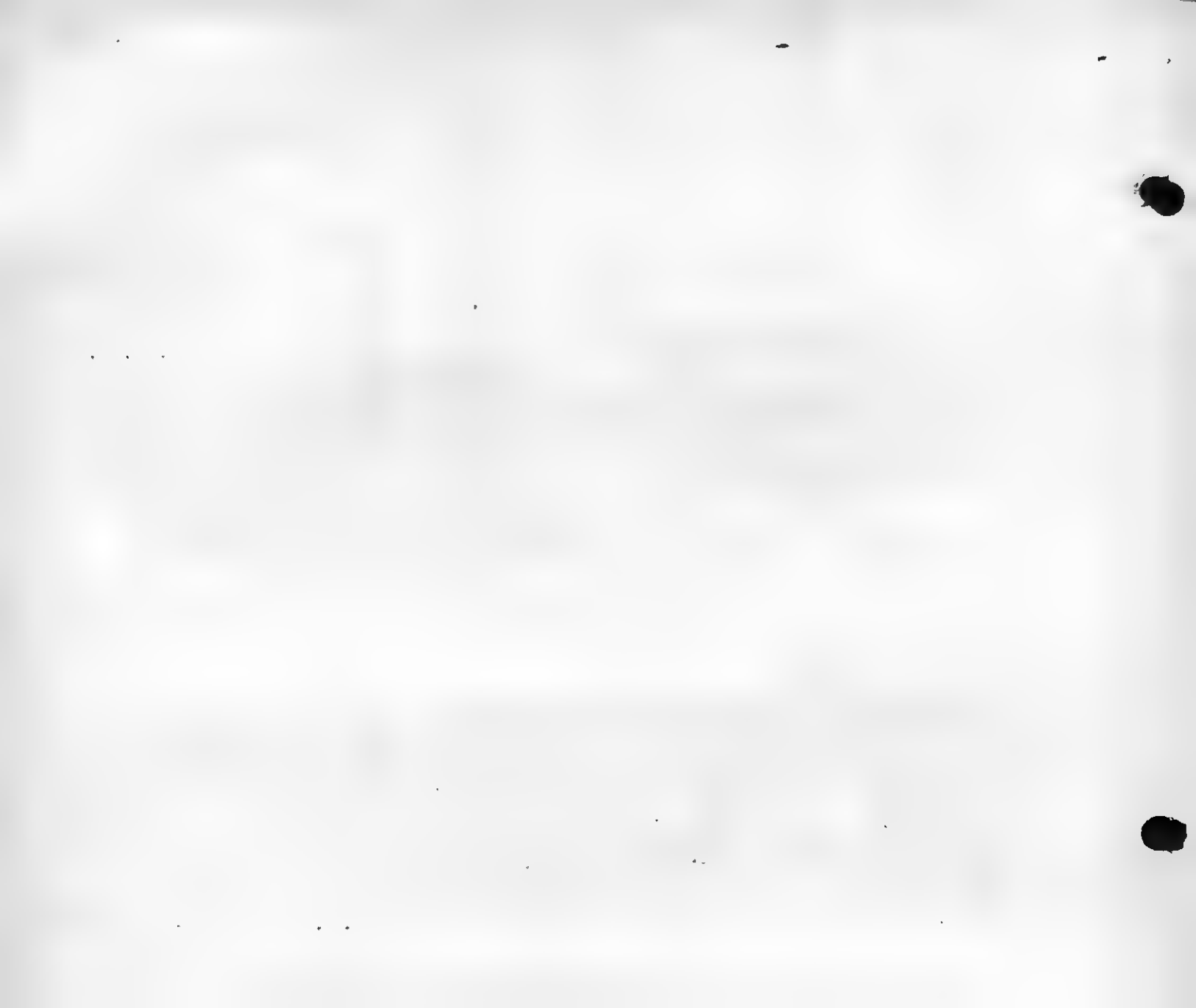
**07615**

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admision) o. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	c. LENGTH OF STAY IN 1b <b>3yr6mth16dys</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harford</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>Carter Street</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Johanna</b> Middle <b>VanBuren</b> Last <b>Kelly</b>		4. DATE OF DEATH Month <b>July</b> Day <b>7</b> Year <b>19 59</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 5, 1878</b>
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months <b>80</b> Days <b>0</b> Hours <b>0</b> Min.	IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Adrain Van Buren</b>	
14. MOTHER'S MAIDEN NAME <b>Bridget Tobin</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac failure</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) <b>Generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>several days</b> <b>many months</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome associated to cerebral arteriosclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>(City or town) (County) (State)</b>
21. I certify that I attended the deceased from <b>April 13, 19 59</b> , to <b>July 7, 19 59</b> , that I last saw the deceased alive on <b>July 7, 19 59</b> , and that death occurred at <b>4:45 p. M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>7-7-59</b>		
ACTUAL SIGNATURE <b>Bruno Radauskas</b> M. D. <b>SPRING GROVE STATE HOSPITAL</b>		
PHYSICIAN'S NAME (Type) <b>BRUNO RADAUSKAS</b> <b>Catonsville 28, Maryland</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/10/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Bakers Cemetery</b>
22d. LOCATION (City, town, or county) <b>R.D. Aberdeen, Maryland</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur L. Kraus</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 13 '59</b>
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>		

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4: may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7638

## CERTIFICATE OF DEATH

Reg. Dist. No.

07616

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE [Where deceased lived If institution Residence before admission] a. STATE <u>Mar land</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>1yr10mth28dsy</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		d. STREET ADDRESS <u>1 South Potomac Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary (Mamie)</u> Middle <u>Agnes</u> Last <u>Kerins</u>		4. DATE OF DEATH Month <u>July</u> Day <u>16</u> Year <u>19 59</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 26, 1879</u>
9. AGE (In years last birthday) <u>79</u> yrs		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Stenographer</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown John C. Kerins</u>		14. MOTHER'S MAIDEN NAME <u>Unknown Elizabeth Dobbins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>Unknown None</u>	
17. INFORMANT <u>Mrs. Edward J. Berrane-7452 Berkshire Rd.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 16</u> , 19 <u>57</u> , to <u>July 16</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 16</u> , 19 <u>59</u> , and that death occurred at <u>1:15p</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stella Wachler</u>		DATE SIGNED <u>SPRING GROVE STATE HOSPITAL 7-16-59</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachler, M. D.</u>		<u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/20/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Moran- 3000 E. Baltimore Street</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 20 1959</u>	
24b. REGISTRAR'S SIGNATURE <u>Chas. S. Kline</u>			



TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7639

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07617

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. LENGTH OF STAY IN 1b <b>X</b> <b>Owings Mills</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>11124 Reisterstown Rd.</b>		e. STREET ADDRESS <b>11124 Reisterstown Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Minerva</b> First <b>Blanche</b> Middle <b>King</b> Last		4. DATE OF DEATH Month <b>July</b> Day <b>21</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 22, 1874</b>
9. AGE (in years last birthday) <b>84</b> yrs.	IF UNDER 1 YEAR Months <b>4</b> Days <b>8</b>	IF UNDER 24 HRS. Hours <b>1</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry H. Nelson</b>		14. MOTHER'S MAIDEN NAME <b>Susan Kendig</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Dorothey King</b>		Address <b>Owings Mills, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured Hip, left</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Generalized Arteriosclerotic C-V Disease</b> (c) <b>5 yrs.</b> DUE TO (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arthritis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Walking on pavement, started to turn and fell by side of road fracturing left hip</b>	
20c. TIME OF INJURY Month, Day, Year <b>7-15-59</b> Hour o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>street</b>		20f. (City or town) (County) (State) <b>Owings Mills, Balto., Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>D. D. Caples</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>D. D. Caples, M. D.</b>		DATE SIGNED <b>7-23-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 24/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Thomas Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Owings Mills Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F.Eline &amp; Sons Reisterstown, Md.</b>		ADDRESS <b>J.F.Eline &amp; Sons Reisterstown, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>Jul 29 59</b>		24b. REGISTRAR'S SIGNATURE <b>William L. Kraus</b>	





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 7640  
 CERTIFICATE OF DEATH

07618

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>57 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROSCOE</b> Middle <b>W.</b> Last <b>KING</b>		4. DATE OF DEATH Month <b>July</b> Day <b>19</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 22, 1879</b>
9. AGE (In years last birthday) yrs <b>80</b>		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sailor (Retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>	
11. BIRTHPLACE (State or foreign country) <b>Murphy, N. Carolina</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>Mark C. King</b>		14. MOTHER'S MAIDEN NAME <b>Molly Baker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>None</b>	
17. INFORMANT <b>Mrs. Rosabel E. King, wife-R.D. #3 Sal. Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> <b>140.9</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CARCINOMA OF LIP</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 Days</b> <b>3 Months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Operation, 6/18/59 Excision- lower lip: Immature spinocellular carcinoma Arteriosclerotic Heart Disease</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA</b> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 23</b> , 19 <b>59</b> , to <b>July 19</b> , 19 <b>59</b> , and that death occurred at <b>8:05 P.</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>7/20/59</b> SIGNATURE <b>John W. Crawford</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b> <b>7/20/59</b> PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b> <b>VAH, FORT HOWARD, MARYLAND</b> <b>7/20/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 23/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>WICOMICO MEMORIAL PARK</b>	22d. LOCATION (City, town, or county) (State) <b>SALISBURY, MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Holloway &amp; Co. Funeral Home, Salisbury, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 23 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hunt</b>



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07619

7641

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rodgers Forge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rodgers Forge</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>45 Dunkirk Rd</u>		e. STREET ADDRESS <u>45 Dunkirk Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>ROBERTA</u> Middle <u>B</u> Last <u>KOONTZ</u>		4. DATE OF DEATH Month <u>July</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 20 1865</u>
9. AGE (In years last birthday) <u>94</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Md</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas E Creamer</u>		14. MOTHER'S MAIDEN NAME <u>Anne E Gardner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Winifred S Koontz</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>10-1</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of stem 18)	
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> Month <u>  </u> Day <u>  </u> Year <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1950</u> to <u>July 26, 1959</u> , that I last saw the deceased alive on <u>July 20, 1959</u> , and that death occurred at <u>2:49</u> M, from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Frederick K. Volmer</u> M.D.		DATE SIGNED <u>8/2/59</u>	
PHYSICIAN'S NAME (Type) <u>FREDERICK K. VOLMER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Aug 3/59</u>	<u>New Cathedral</u>	<u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W Jenkins</u>		24a. REC'D BY REGISTRAR <u>Aug 3 '59</u>	
ADDRESS <u>4905 York Rd</u>		24b. REGISTRAR'S SIGNATURE <u>Robert S. Hume</u>	



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7642

CERTIFICATE OF DEATH

07620

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o STATE <u>Md.</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>			
c. LENGTH OF STAY IN 1b <u>80yrs.</u>				d. STREET ADDRESS <u>Worden Saw Mill Rd.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Worden Saw Mill Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Krout</u> Last <u>Krout</u>				4. DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 5 1876</u>	9. AGE (In years and months) <u>83</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm.</u>		11. BIRTHPLACE (State or foreign country) <u>Stewartstown Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Abraham Krout</u>				14. MOTHER'S MAIDEN NAME <u>Mary Waltemyer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or last town) <u>No</u>				16. SOCIAL SECURITY NO <u></u> INFORMANT <u>Mrs. Alice Krout, Parkton, Md. R.D.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accident.</u> 551X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Advanced Arterio-Sclerosis</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>15 yrs.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Broncho-Pneumonia</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1, 1959</u> , to <u>July 1, 1959</u> , that I last saw the deceased alive on <u>July 1, 1959</u> , and that death occurred at <u>330 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William O. Fulton</u> M.D.				DATE SIGNED <u>6/2/59</u>			
PHYSICIAN'S NAME (Type) <u>William O. Fulton</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>7/3/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Stahlersville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Parkton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein</u>				24a. REC'D BY REGISTRAR <u></u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Hurd</u>	
ADDRESS <u>New Freedom Pa.</u>				DATE <u>JUL 6 '59</u>			



7643

Item 1 Film 246 8-3-59 et

CERTIFICATE OF DEATH

07621

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Md.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>	
c. LENGTH OF STAY IN TB <b>3 Mo.</b>		d. STREET ADDRESS <b>1914 Oak Drive</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Daughter's home 35 Belle Grove Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Antoinette</b> Middle <b>R.</b> Last <b>LaVoie</b>		4. DATE OF DEATH Month <b>July</b> Day <b>29</b> Year <b>1959</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 18, 1893</b>
9. AGE (in years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>10</b> Hours <b>15</b> Min.	IF UNDER 24 HRS Hours <b>15</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>O.H.</b>	11. BIRTHPLACE (State or foreign country) <b>Mass.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Adelaird Gignac</b>	
14. MOTHER'S MAIDEN NAME <b>Olivine Pontbriand</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>Mr Homer A. LaVoie, 1914 Oak Dr. Balto. #7, Md</b>		INFORMANT <b>Address</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of the Liver</b> <b>106.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1947</b> to <b>July 29, 1959</b> that I last saw the deceased alive on <b>July 28, 1959</b> and that death occurred at <b>12:15 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. C. Powner</b>		DATE SIGNED <b>3325 Frederick Ave Balto 29 mo</b>	
PHYSICIAN'S NAME (Type) <b>J. C. Powner</b>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/1/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cem'ty</b>	22d. LOCATION (City, town, or county) (State) <b>Woodlawn Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Dir. 4101 Edmondson Ave.</b>		24a. REC'D BY REGISTRAR <b>DATE JUL 30 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





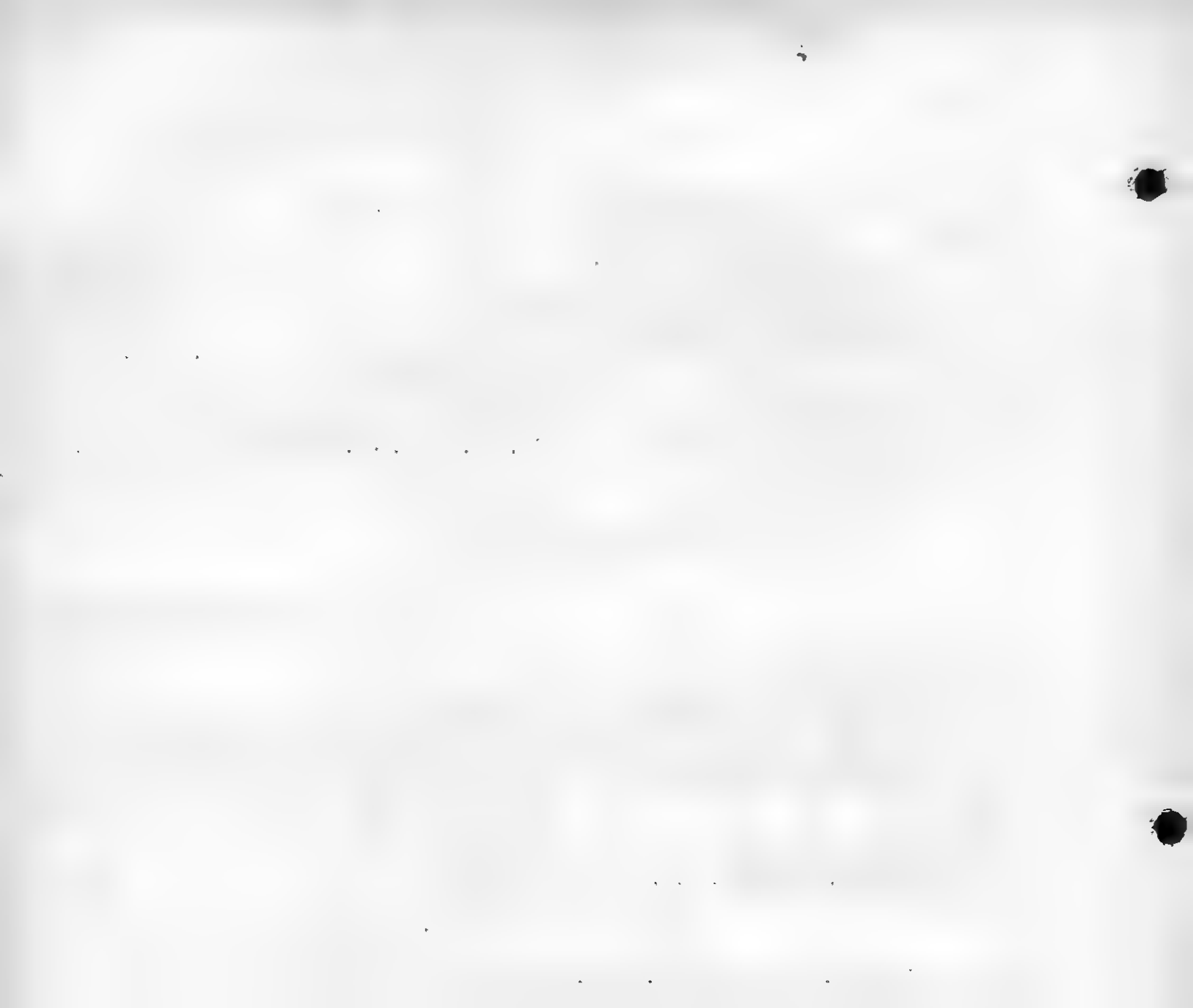
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**7644**  
**CERTIFICATE OF DEATH**

Reg. Dist. No. **07622**

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>			c. LENGTH OF STAY IN 1b <b>37 Days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore (15)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>6962 Reisterstown Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>GARNETT</b> Middle <b>G.</b> Last <b>LEE</b>				4. DATE OF DEATH Month <b>July</b> Day <b>21</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 18, 1918</b>		9. AGE (In years last birthday) yrs. <b>40</b>	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bricklayer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Donald Lee</b>				14. MOTHER'S MAIDEN NAME <b>Helen Schillinger</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO (If yes, give year or dates of service) <b>WW II 214-18-1437</b>		17. INFORMANT Address <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b>							<b>1 MONTH</b>
DUE TO <b>CHRONIC GLOMERULONEPHRITIS</b>							<b>13 YEARS</b>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 14</b> , 19 <b>59</b> , to <b>July 21</b> , 19 <b>59</b> and that death occurred at <b>1:30 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>John W. Crawford</i>				ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b>		DATE SIGNED <b>7/21/59</b>	
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>				<b>VAH, FORT HOWARD, MARYLAND</b>		<b>7/21/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-23-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Lewis, Inc. 2100 Patuxent Pl. Balto. Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 23 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Christina L. Lewis</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

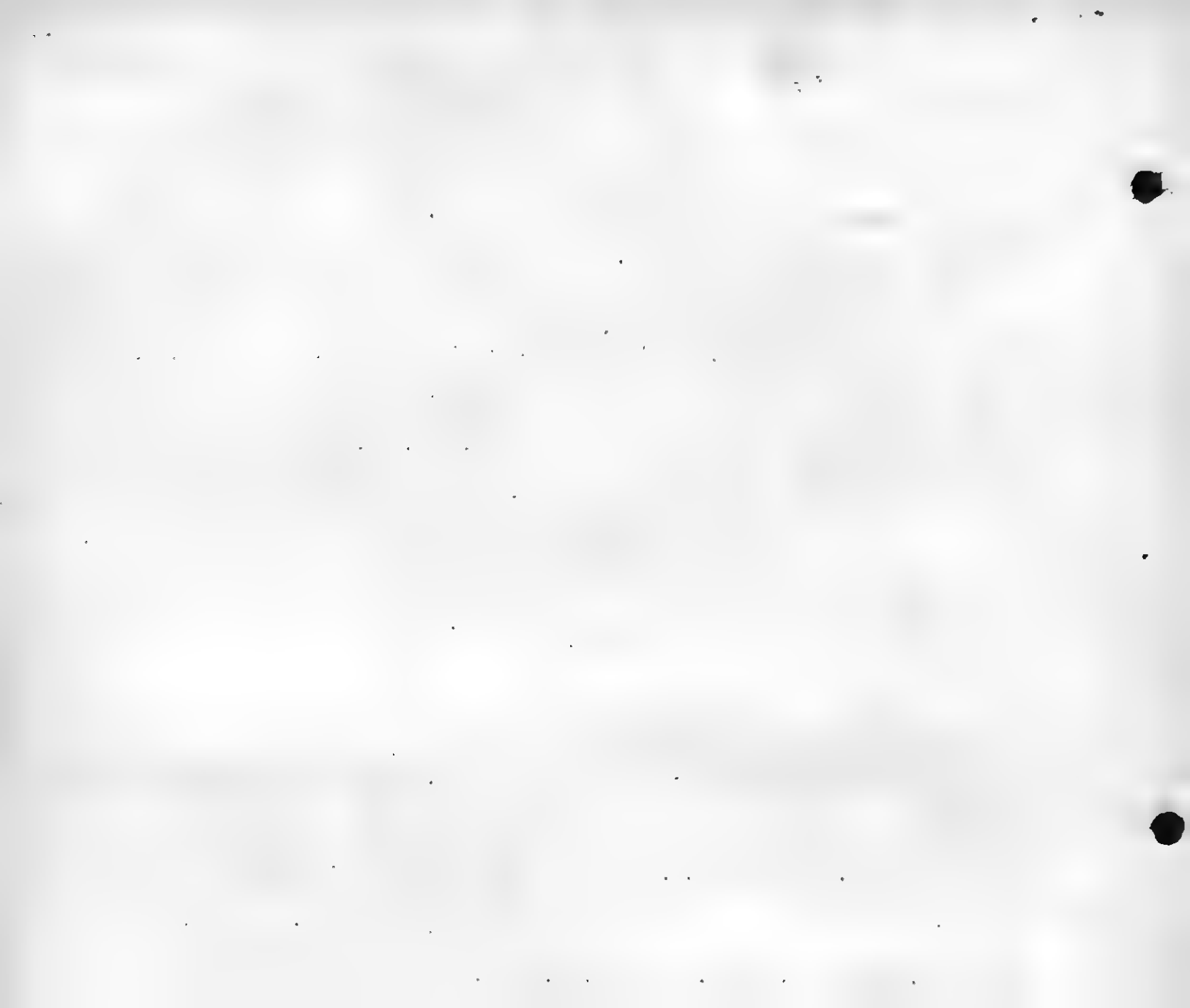
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7645

## CERTIFICATE OF DEATH

Reg. Dist. No. 07623

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>7 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. STREET ADDRESS <b>1023 N. Milton Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>KENNETH</b> Middle <b>V.</b> Last <b>LEE</b>		4. DATE OF DEATH Month <b>July</b> Day <b>23</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 6, 1893</b>
9. AGE (in years last birthday) yrs. <b>66</b>		10. IF UNDER 1 YEAR: Months <b>23</b> Days <b>19</b> HRS <b>59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Elevator Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't Printing Office</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>Jasper Lee</b>		14. MOTHER'S MAIDEN NAME <b>Josephine Hatton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give year or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE WITH CONGESTIVE FAILURE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>URINARY EXTRAVASATION DUE TO RUPTURED URETHRA DUE TO BENIGN PROSTATIC HYPERTROPHY</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c): <b>Cystostomy-Chronic ulceration penis &amp; scrotum. Incisional wounds, anterior abdominal wall and scrotum.</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 16, 1959</b> to <b>July 23, 1959</b> and that death occurred at <b>8:55 P.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>VAH, FORT HOWARD, MARYLAND 7/24/59</b>			
ACTUAL SIGNATURE <b>John W. Crawford</b>		M.D. <b>VAH, FORT HOWARD, MARYLAND</b>	
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>		<b>VAH, FORT HOWARD, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/23/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph G. Locks, Jr.</b>		ADDRESS <b>1304 N. Central Ave. Balto.</b>	
24a. REC'D BY REGISTRAR <b>DA 27 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7646 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07624

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>15-1</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8030 Norris Lane</u>				d. STREET ADDRESS <u>8030 Norris Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Timothy</u> Middle <u>Lee</u> Last <u>Lee</u>				4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>19 59</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 3, 1953</u>	
9. AGE (In years last birthday) <u>6</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Lee</u>				14. MOTHER'S MAIDEN NAME <u>Alberta Dawson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>66666- None</u>		17. INFORMANT Address <u>Alberta Dawson Lee 8030 Norris Lane</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Vascular malformation of brain</u> <u>753.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>  </u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>  </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>William V. Lovitt, Jr.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>7/3/59</u>	
EXAMINER'S NAME (Type) <u>William V. Lovitt, Jr., M.D.</u>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-6-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Law</u>				ADDRESS <u>802 Madison Avenue</u>		24a. REC'D BY REGISTRAR <u>JUL 6 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knapp</u>			



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7647

## CERTIFICATE OF DEATH

Reg. Dist. No.

07625

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex (21)</b>				c. LENGTH OF STAY IN 1b <b>54</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>316 Riverside Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOSEPH JAMES LEPKA</b>				4. DATE OF DEATH Month Day Year <b>July 25, 19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 11, 1905</b>	
9. AGE (In years last birthday) <b>54</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tavern Operator</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Tavern</b>			
13. FATHER'S NAME <b>Martin Lepka</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Vacek</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>213-10-4892</b>		17. INFORMANT <b>Helen German</b> Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>177X</b> DUE TO <b>Melanotic carcinoma to lungs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Prostate</b> (c) <b>4 - the</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>July 25, 19 59</b> to <b>July 25, 19 59</b> that I last saw the deceased alive on <b>July 25, 19 59</b> and that death occurred at <b>6:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>316 Riverside Ave. Baltimore, Md.</b> DATE SIGNED <b>7/25/59</b>							
ACTUAL SIGNATURE <b>James E. Bruzdinski</b> M.D.							
PHYSICIAN'S NAME (Type) <b>James E. Bruzdinski</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/28/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James E. Bruzdinski</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw</b>	





TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coffin papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7648

## CERTIFICATE OF DEATH

Reg. Dist. No.

07626

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>MARYLAND</b> b. COUNTY <b>BALT. CITY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>		c. LENGTH OF STAY IN 1b <b>2 MONTHS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>		d. STREET ADDRESS <b>505 Montgomery St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Randolph</b> First <b>NATHAN</b> Middle <b>Lowery</b> Last		4. DATE OF DEATH <b>July</b> Month <b>13</b> Day <b>1959</b> Year	
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>6-10-1904</b>
9. AGE (In years last birthday) <b>55</b> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>W.H. Kirkwood Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Lowery</b>		14. MOTHER'S MAIDEN NAME <b>SARAH RIVERS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-01-1626</b>	
17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac arrest</b> <b>102X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>coronary - infarction</b> (c) <b>pulmonary tuberculosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>Immediate</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Right upper lobectomy &amp; post-op bronchospasm</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5-27</b> , 19 <b>59</b> , to <b>7-13</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7-13</b> , 19 <b>59</b> , and that death occurred at <b>3:40 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Mt. Wilson, Maryland</b> DATE SIGNED			
ACTUAL SIGNATURE <b>William Newcomer</b> M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>		Superintendent	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>7/17/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank H. Newell</b>		24a. REC'D BY REGISTRAR <b>Jul 20 '59</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Hanna</b>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7649

CERTIFICATE OF DEATH

Reg. Dist. No. 07627

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>aa</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Forrest Haven Nursing Home</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. STREET ADDRESS <u>161 Green St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Elizabeth</u> Last <u>Mace</u>		4. DATE OF DEATH Month <u>7-</u> Day <u>25-</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-13-1874</u>
9. AGE (In years (or bimonthly) yrs. <u>85</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>		13. FATHER'S NAME <u>James H. Mace</u>	
14. MOTHER'S MAIDEN NAME <u>Margaret Williams</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO <u>No</u>		17. INFORMANT <u>John H. Mace</u> Address <u>(2)</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA BILATERAL -</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>ARTERIO SCLEROTIC CARDIO - VASCULAR DISEASE</u> DUE TO (c) <u>Uremia</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>7/9</u> , 19 <u>59</u> , to <u>7/25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7/25</u> , 19 <u>59</u> , and that death occurred at <u>3:30</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>John H. Shaw</u> M.D. <u>5800 EDMONDSON AVE</u> <u>7/27/59</u>			
PHYSICIAN'S NAME (Type) <u>John H. Shaw M.D.</u> <u>BALTIMORE, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>July 28-59</u>	<u>St Annes</u>	<u>Annapolis Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Taylor</u>		24a. REC'D BY REGISTRAR <u>Jul 29 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7650

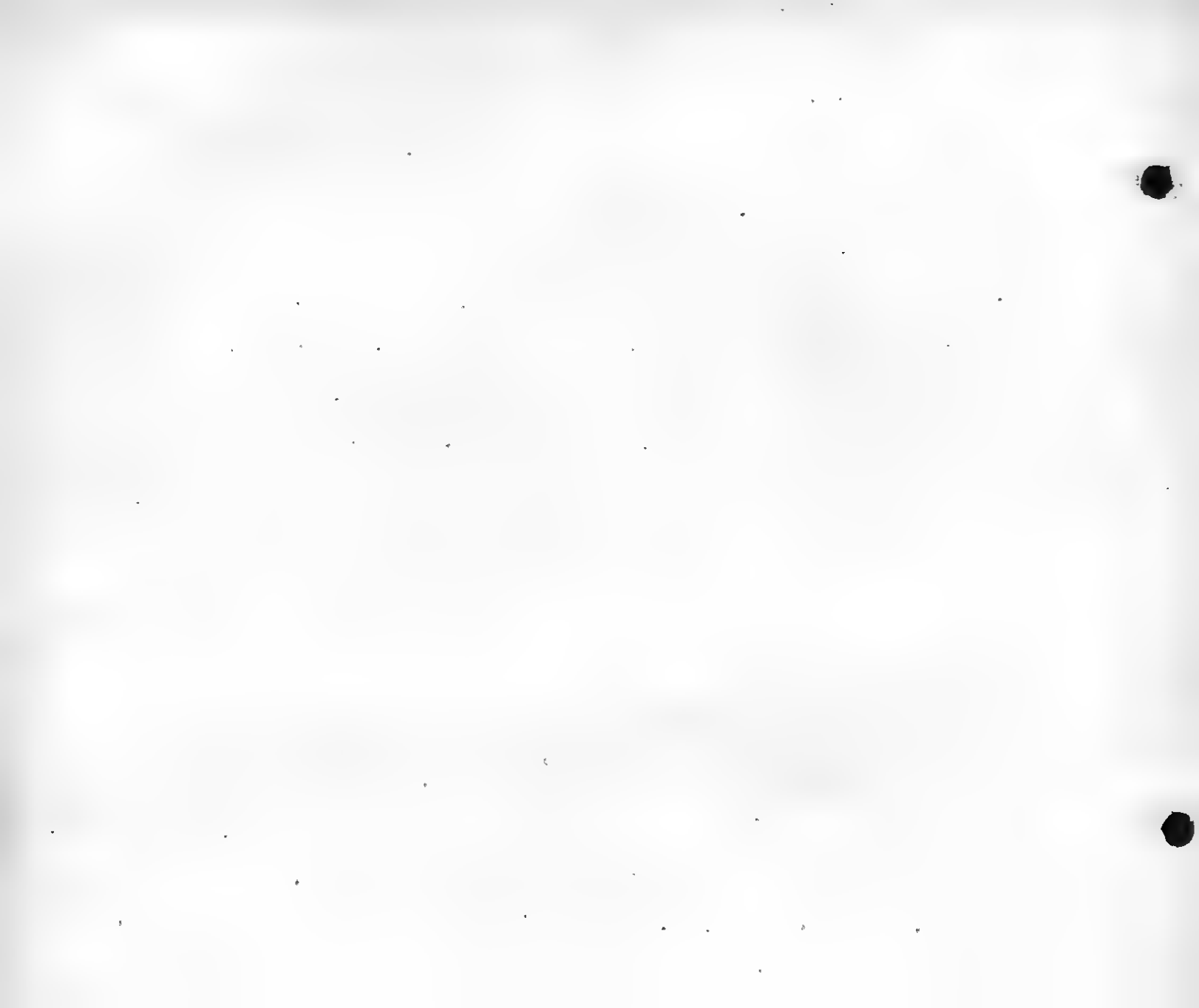
## CERTIFICATE OF DEATH

Reg. Dist. No. **07628**

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.2em;">Baltimore</span> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution Residence before admission) a. STATE <span style="font-size: 1.2em;">Maryland</span> <span style="float: right;">b. COUNTY <span style="font-size: 1.2em;">Baltimore</span></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Catonsville</span>			c. LENGTH OF STAY IN 1b <span style="font-size: 1.2em;">3 Years</span>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <span style="font-size: 1.2em;">Catonsville</span>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <span style="font-size: 1.2em;">Shady-Nook Nursing and Convalescent</span>				d. STREET ADDRESS <span style="font-size: 1.2em;">1 Overbrook Road</span>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <span style="font-size: 1.2em;">EMMA</span> Middle <span style="font-size: 1.2em;">C.</span> Last <span style="font-size: 1.2em;">MAHIE</span>				<b>4. DATE OF DEATH</b> Month <span style="font-size: 1.2em;">July</span> , Day <span style="font-size: 1.2em;">23rd</span> , Year <span style="font-size: 1.2em;">19 59</span>			
<b>5. SEX</b> <span style="font-size: 1.2em;">Female</span>		<b>6. COLOR OR RACE</b> <span style="font-size: 1.2em;">White</span>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">Sept. ? 1872</span>		<b>9. AGE</b> (In years lost birthday) <span style="font-size: 1.2em;">86</span> yrs.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">At home</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Baltimore, Maryland</span>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">USA</span>	
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Jacob Mahle</span>				<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Caroline Swartz</span>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">None</span>		<b>INFORMANT</b> Address <span style="font-size: 1.2em;">Melvin J. Muhly- 1 Overbrook Road</span>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]							INTERVAL BETWEEN ONSET AND DEATH
<b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <span style="font-size: 1.2em;">Right Hemiplegia</span>							<span style="font-size: 1.2em;">4 days</span>
DUE TO <span style="font-size: 1.2em;">Hypertension</span>							<span style="font-size: 1.2em;">10 years</span>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							DUE TO (b)
DUE TO (c)							DUE TO (c)
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)			
<b>20c. TIME OF INJURY</b> Hour <span style="font-size: 1.2em;">19</span> a. m. <span style="font-size: 1.2em;">p. m.</span>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <span style="font-size: 1.2em;">July 19, 1959</span> <b>to</b> <span style="font-size: 1.2em;">July 23, 1959</span> <b>that I last saw the deceased alive on</b> <span style="font-size: 1.2em;">July 22, 1959, 19</span> <b>and that death occurred at</b> <span style="font-size: 1.2em;">7:05 M.</span> <b>from the causes and on the date stated above.</b>							
<b>ACTUAL SIGNATURE</b> <span style="font-size: 1.2em;">George E. Shannon</span>				<b>ADDRESS</b> (Street, city or town, state) <span style="font-size: 1.2em;">820 Medical Arts Building</span>		<b>DATE SIGNED</b> <span style="font-size: 1.2em;">7/24/59</span>	
<b>PHYSICIAN'S NAME (Type)</b> <span style="font-size: 1.2em;">George E. Shannon, M.D.</span>				<span style="font-size: 1.2em;">Baltimore 1, Md.</span>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span>		<b>22b. DATE THEREOF</b> <span style="font-size: 1.2em;">July, 25 1959</span>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Loudon Park Cem</span>		<b>22d. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Maryland</span>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <span style="font-size: 1.2em;">Charles Lamotteau</span>				<b>ADDRESS</b> <span style="font-size: 1.2em;">1003 W. Balto. St.</span>		<b>24a. REC'D BY REGISTRAR</b> <span style="font-size: 1.2em;">JUL 27 '59</span>	
<b>24b. REGISTRAR'S SIGNATURE</b> <span style="font-size: 1.2em;">Orlinda L. Hanna</span>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

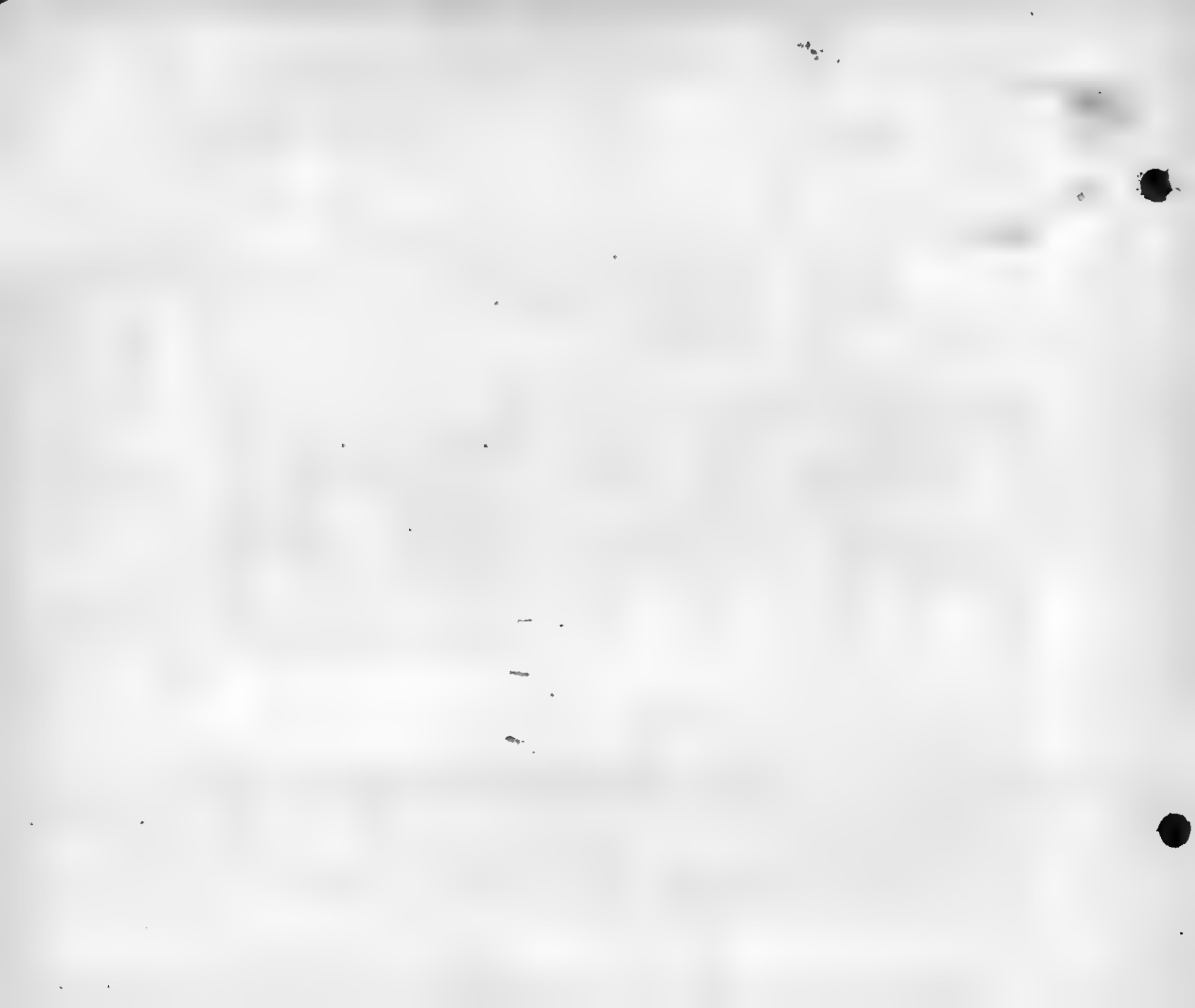
7651

## CERTIFICATE OF DEATH

07629

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ivy Hall Nursing Home</u>		d. STREET ADDRESS <u>6915 Beech Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or Print) First <u>William</u> Middle <u>C.</u> Last <u>Markle</u>		4. DATE OF DEATH Month <u>July</u> Day <u>10</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 6, 1881</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Markle</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Thompson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>042-18-6006</u>	
17. INFORMANT <u>James A. Markle</u>		Address <u>Rt. 14 Box 619</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic cardiac vascular disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <u>19</u> Month, Day, Year p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1959</u> to <u>July 10, 1959</u> , that I last saw the deceased alive on <u>July 10, 1959</u> , and that death occurred at <u>4:55</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis Semenovoff</u>		ADDRESS (Street, city or town, state) <u>2108 OREMUS RD Baltimore MD</u>	
DATE SIGNED <u>7/10/59</u>			
PHYSICIAN'S NAME (Type) <u>LOUIS SEMENOVFF</u>		<u>Baltimore MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 13, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Gardens Of Faith</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>		ADDRESS <u>7401 Belair Rd</u>	
24a. REC'D BY REGISTRAR <u>DATE JUL 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	





TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4-1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7652

## CERTIFICATE OF DEATH

07630

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN 1b <i>30 yrs.</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Baltimore</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>6902 Norman Avenue</i>		d. STREET ADDRESS <i>1 6902 Norman Avenue</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Charles F.</i> Middle <i>Martin</i> Last		4. DATE OF DEATH Month <i>July</i> Day <i>22</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 8, 1891</i>
9. AGE (In years, top birthday) yrs. <i>68</i>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Electric Crane Operator</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Beth. Steel Co.</i>	
11. BIRTHPLACE (State or foreign country) <i>Fredericksburg, Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Frank Martin</i>		14. MOTHER'S MAIDEN NAME <i>? Bowen</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <i>Yes</i>	
17. INFORMANT Address <i>Mrs. William B. Wallace-6902 Norman Ave. Z22</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> DUE TO (b) <i>Chronic nephritis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <i>3 yrs.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>15 min.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>11/21/1958</i> to <i>7/22/1959</i> , that I last saw the deceased alive on <i>7/20/1959</i> , and that death occurred at <i>3:20 P. M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>David H. Andrew</i> M.D.		ADDRESS (Street, city or town, state) <i>33 Dundalk Ave</i>	
PHYSICIAN'S NAME (Type) <i>DAVID H. ANDREW</i>		DATE SIGNED <i>7/24/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/25/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Sacred Heart of Mary Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John A. Moran-3000 E. Baltimore Street</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 27 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Christina E. Hines</i>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME  
SM 2 '57

7653

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07631

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <b>SPARROWS POINT MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPARROWS POINT Desp.</u>		d. STREET ADDRESS <u>1712 N. Bond St.</u>	
3. NAME OF DECEASED (Type or print) First <u>RUFUS</u> Middle <u>MASON JR.</u> Last <u>JR.</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>2</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 10/1936</u>
9. AGE (In years last birthday) <u>23</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	
11. BIRTHPLACE (State or foreign country) <u>Greenville N.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>RUFUS MASON Sr.</u>		14. MOTHER'S MAIDEN NAME <u>EMMA Brewington</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or not known) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MABLE MASON</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental Electrocution</u> 9143 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Struck in corner of U. Wire while working =</u>	
20c. TIME OF INJURY Month, Day, Year <u>July 2 1959</u>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, other place, etc.) <u>Baltimore</u>	20f. City or town <u>Baltimore</u> (County) <u>Md.</u> (State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M. B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M. B. Davis M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>JULY 6, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CARYER MEM PARK</u>		22d. LOCATION (City, town, or county) (State) <u>LAUREL Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Miller E. Elckman</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 8 59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Robert A. Thacker</u>	

DATE SIGNED  
7/2/59 =



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7654 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07632

Reg. Dist. No.

**FOR STATE  
HEALTH DEPT.**

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The New HAVEN Bldg. &amp; CTN Co. BALTIMORE, MD.</b>		e. STREET ADDRESS <b>61 Winters Lane</b>	
3. NAME OF DECEASED (Type or print) First <b>RAYMOND</b> Middle <b>ELIAS</b> Last <b>MATTHEWS</b>		4. DATE OF DEATH Month <b>July</b> Day <b>20<sup>th</sup></b> Year <b>19 59</b>	
5. SEX <b>M</b>		6. COLOR OR RACE <b>Negro</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Sept 15, 1900</b>	
9. AGE (in years last birthday) <b>58</b> yrs.		10. IF UNDER 1 YEAR: Months <b>1</b> Days <b>15</b> Hours <b>15</b> Min <b>15</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNITOR</b>		12. KIND OF BUSINESS OR INDUSTRY <b>FOLDING BOXES</b>	
13. BIRTHPLACE (State or foreign country) <b>MD.</b>		14. CITIZEN OF WHAT COUNTRY? <b>American</b>	
15. FATHER'S NAME <b>Charles Matthews</b>		16. MOTHER'S MAIDEN NAME <b>Mary ADAMS.</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		18. SOCIAL SECURITY NO. <b>216-14-2017</b>	
19. INFORMANT <b>Raymond Eugene Matthews, #28.</b>		20. 19 DUNBAR Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>15 min?</b> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>No injury</b>	
20c. TIME OF INJURY Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>George H. Friskey</b>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>George H. FRISKEY, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-24-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Western Star Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James Hemaly, 578 N. Biddle St</b>		ADDRESS <b>Baltimore Md</b>	
24a. REC'D BY REGISTRAR <b>JUL 23 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7655 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **07633**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Baltimore</b></span>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Lower dam, Loch Raven Dam</b>		d. STREET ADDRESS <b>906 Cathedral Street</b>	
<b>3. NAME OF DECEASED</b> (Type or print) <span style="float: right;">First Middle Last</span> <b>WILLIAM ARTHUR MC CARDELL</b>		<b>4. DATE OF DEATH</b> Month <b>July</b> Day <b>24</b> Year <b>19 59</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Oct. 30, 1942</b>
<b>9. AGE</b> (In years last birthday) <b>16</b> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Clerk</b>	<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Newspaper</b>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>
<b>13. FATHER'S NAME</b> <b>Paul J. McCardell, Sr.</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Emma Edwards</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>216-40-0876</b>	
<b>17. INFORMANT</b> <b>Paul McCardell, Sr., 3001 Delmar Ave., Baltimore 19, Md.</b>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a) Asphyxia</b> <b>7298 DUE TO drowning</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(b)</b> <b>DUE TO (c)</b>	
<b>19. WAS AUTOPSY PERFORMED?</b> <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		<b>20. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Found drowned in Loch Raven Dam</b>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>7/23/59</b> Hour <b>10</b> <del>XXXX</del> p. m.		<b>20d. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Loch Raven Dam</b>	
<b>20e. (City or town)</b> <b>Towson</b>		<b>20f. (County)</b> <b>Baltimore</b>	
<b>20g. (State)</b> <b>Md.</b>		<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> <b>Accident</b> <input checked="" type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined cause</b> <input type="checkbox"/>	
<b>ACTUAL SIGNATURE</b> <i>Charles S. Petty</i>		<b>DATE SIGNED</b> <b>7/24/59</b>	
<b>EXAMINER'S NAME (Type)</b> <b>Charles S. Petty, M.D.</b>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>7/27/59</b>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Ebenezer Methodist</b>		<b>22d. LOCATION (City, town, or county)</b> <b>Chase, Maryland</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Walter Brooks Bradley, Inc.</i>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>JUL 28 '59</b>	
<b>ADDRESS</b> <b>Dundalk 22</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Kraus</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7656

## CERTIFICATE OF DEATH

Reg. Dist. No.

07634

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>274 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>1429 John Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>PAUL</b> Middle <b>D.</b> Last <b>MC CLURE</b>		4. DATE OF DEATH Month <b>July</b> Day <b>16</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>May 31, 1899</b>
9. AGE (In years on birthday) <b>60</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pay Roll Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Company</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>Louis R. McClure</b>		14. MOTHER'S MAIDEN NAME <b>Jane E. Heath</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b> (If yes, give year or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>216-07-1270</b>	
17. INFORMANT <b>Clin. Rec. Vet. Adm. Hospital, Fort Howard, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>EPENDYMOA OF CAUDA EQUINA WITH METASTASIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>5 YEARS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month _____ Day _____ Year <b>19 59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>October 15, 19 58</b> , to <b>July 16, 19 59</b> , and that death occurred at <b>11:05 P.M.</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>John W. Crawford</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b> <b>7/17/59</b> PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b> <b>VAH, FORT HOWARD, MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-20-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		22d. LOCATION (City, town, or county) _____ (State) _____ <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jenkins and Sons, Inc. 4905 York Road, Balto., Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 20 59</b>	
24b. REGISTRAR'S SIGNATURE			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7657

## CERTIFICATE OF DEATH

Reg. Dist. No.

07635

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. LENGTH OF STAY IN 1b <b>31 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Academy Lane</b>		e. STREET ADDRESS <b>Academy Lane</b>	
3. NAME OF DECEASED (Type or print) First <b>Joshua</b> Middle <b>Aquilla</b> Last <b>McComas</b>		4. DATE OF DEATH Month <b>July</b> Day <b>21</b> Year <b>1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 9 1888</b>
9. AGE (In years last birthday) yrs. <b>71</b>		IF UNDER 1 YEAR: Months <b>7</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm helper</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Sommerville McComas</b>		14. MOTHER'S MAIDEN NAME <b>Annie Shipley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>220-05-9581</b>	
17. INFORMANT <b>Mrs J A McComas</b>		Address <b>Owings Mills Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>4</b> DUE TO <b>General arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>four years</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>15 minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <input checked="" type="checkbox"/>		20f. (City or town) <b>Reisterstown</b> (County) <b>Md</b> (State)	
21. I certify that I attended the deceased from <b>1-1-1930</b> to <b>7-21-59</b> , that I last saw the deceased alive on <b>7-21-59</b> , and that death occurred at <b>7:20</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James G. Saffell</b> M.D.		DATE SIGNED <b>7-22-59</b>	
PHYSICIAN'S NAME (Type) <b>James G. Saffell MD</b>		<b>Reisterstown Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 24 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Deer Park Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Reisterstown Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Oliver W. Berryman</b>		24a. REC'D BY REGISTRAR <b>Reisterstown Md</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hume</b>		DATE <b>JUL 24 '59</b>	



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or offending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7658

CERTIFICATE OF DEATH

07636

Reg. Dist. No. 32

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson</b>		c. LENGTH OF STAY IN 1b <b>1937</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>		d. STREET ADDRESS <b>CALVARY SECTION</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>SADIE CATHERINE McCREADY</b>		4. DATE OF DEATH Month Day Year <b>JULY 1 1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 21 1886</b>
9. AGE (In years lost birthday) <b>72 yrs</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWORK</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11c. BIRTHPLACE (State or foreign country) <b>TANGIER ISLAND VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN DISE</b>		14. MOTHER'S MAIDEN NAME <b>LAURA PARKS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO (b) <b>PULMONARY FIBROSIS (UNDETERMINED ORIGIN)</b> (c) <b>SENIORITY</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>SENIORITY</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/20</b> 19 <b>59</b> , to <b>7/1</b> 19 <b>59</b> , that I last saw the deceased alive on <b>7/1</b> 19 <b>59</b> , and that death occurred at <b>11:55 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>William Newcomer</b> M.D.		Mt. Wilson, Maryland	
PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>		Superintendent	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 4, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Asbury</b>		22d. LOCATION (City, town, or county) (State) <b>Crisfield Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James Lennon, Crisfield Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <b>JUL 7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
765 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 07637									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>27 N. Rolling Road</b>					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> d. STREET ADDRESS <b>27 N. Rolling Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>ELLEN</b> Middle <b>MAY</b> Last <b>McKEE</b>					4. DATE OF DEATH Month <b>July</b> Day <b>2</b> Year <b>1959</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/7/21</b>		9. AGE (In years last birthday) <b>38 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School Board</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Louis Snayer</b>					14. MOTHER'S MAIDEN NAME <b>Ellen Whiteley</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Edwin McKee</b> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Tofranil Poisoning.</b> <b>971.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Ingested overdose of Tofranil</b>					
20c. TIME OF INJURY Hour <b>?</b> a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Catonsville</b> (County) <b>Baltimore</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <b>Russell S. Fisher</b> M.D.					CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>				
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
<b>Burial</b>		<b>7/6/59</b>		<b>Western</b>		<b>Balto. Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Russell S. Fisher &amp; Son</b> ADDRESS <b>28</b>					24a. REC'D BY REGISTRAR DATE <b>JUL 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Russell S. Fisher</b>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





TO HOSPITAL: ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7660

## CERTIFICATE OF DEATH

Reg. Dist. No.

07638

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				c. LENGTH OF STAY IN 1b <b>X</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>145 Stanmore Rd.</b>				d. STREET ADDRESS <b>145 Stanmore Rd.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Philip</b> Last <b>McMahon</b>				4. DATE OF DEATH Month <b>July</b> Day <b>18</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-5-1887</b>	
9. AGE (in years last birthday) <b>72</b> yrs		IF UNDER 1 YEAR Months <b>72</b> Days <b>18</b> Hours <b>18</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Gas &amp; Electric</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gas &amp; Electric</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Bernard McMahon</b>		14. MOTHER'S MAIDEN NAME <b>Mary Connolly</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>212-05-5919</b>		17. INFORMANT <b>Elizabeth McMahon</b>		Address <b>same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crowning Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio Sclerosis</b> DUE TO (c) <b>Seriously</b>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Seriously</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 16, 1959</b> to <b>July 18, 1959</b> , that I last saw the deceased alive on <b>July 16, 1959</b> , and that death occurred at <b>5:00</b> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Alfred Byerly</b> M.D.				ADDRESS (Street, city or town, state) <b>3033 W. K. Ave</b>			
DATE SIGNED <b>July 16, 1959</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-21-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck</b>				ADDRESS <b>5305 41 arford Rd.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 22 '59</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kins</b>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7661

## CERTIFICATE OF DEATH

Reg. Dist. No. 07639

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Presbyterian Home of Maryland</b>				e. STREET ADDRESS <b>2532 Arunah Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>KATHERINE</b> Middle <b>H.</b> Last <b>MEISTER</b>				4. DATE OF DEATH Month <b>July</b> Day <b>25</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 21, 1869</b>	9. AGE (In years last birthday) <b>90</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>J. Leonard Hoffman</b>				14. MOTHER'S MAIDEN NAME <b>Olivia Frances DeShields</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <b>Records of Presbyterian Home Towson, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>420.1 Acute coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>  <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 1, 19 58</b> , to <b>July 25, 19 59</b> , that I last saw the deceased alive on <b>July 23, 19 59</b> , and that death occurred at <b>9:50 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7215 York Road</b> DATE SIGNED <b>July 25, 1959</b>							
ACTUAL SIGNATURE <b>[Signature]</b> M.D. <b>7215 York Road</b>				DATE SIGNED <b>July 25, 1959</b>			
PHYSICIAN'S NAME (Type) <b>S.J. Venable, Jr. M.D.</b>				<b>Baltimore 12, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 28, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons Inc. 1900 Eutaw Place</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 29 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Cirilo S. Kraus</b>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7662

## CERTIFICATE OF DEATH

Reg. Dist. No.

07640

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived) If institution Residence before admission a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Villa Nova</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Robb Nursing Home</b>		d. STREET ADDRESS <b>2112 Lorraine Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <b>SABILA</b> Middle <b>V.</b> Last <b>MELCHIOR</b>		4. DATE OF DEATH Month <b>July</b> Day <b>1</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 12, 1868</b>
9 AGE (In years last birthday) yrs. <b>91</b>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <b>Wilmington, Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frederick Herting</b>		14. MOTHER'S MAIDEN NAME <b>Johanna Melchior</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>None</b>	
17 INFORMANT <b>Mrs. Rhoda I. Wagner-2112 Lorraine Ave.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis with cardiovascular disease (old age)</b> 402.1 DUE TO <b>cardiovascular disease (old age)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>no</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/1</b> , 19 <b>59</b> , to <b>7/1</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7/1</b> , 19 <b>59</b> , and that death occurred at <b>7:15</b> AM, from the causes and on the date stated above * <b>DR ABBOTT wife 6/24/59</b> <b>DR M. SCHLENOFF 6/29-6/30/59</b> ADDRESS (Street, city or town, state) <b>333 BEAUMONT AVE #28</b> DATE SIGNED <b>7/1/59</b> ACTUAL <b>Matyas Relle</b> M.D. PHYSICIAN'S NAME (Type) <b>MATYAS RELLE</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/4/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ellsworth Armacost</b> ADDRESS <b>Ellsworth Armacost-4600 Liberty Heights Ave.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 6 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>William L. Francis</b>			



7663

## CERTIFICATE OF DEATH

07641

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balta. City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u> 4		c. LENGTH OF STAY IN 1b <u>4 1/2 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor aged home</u>		d. STREET ADDRESS <u>Latrobe Apt's Charles &amp; Read Sts</u>	
3. NAME OF DECEASED (Type or print) <u>SARAH (SALLY) McPHERSON MIDDLETON</u>		4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1878</u>
9. AGE (in years last birthday) <u>86</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS Months <u>8</u> Days <u>17</u> Hours <u>0</u> M.n. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>S. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas A. Middleton</u>		14. MOTHER'S MAIDEN NAME <u>Mary Beane</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Thomas F. Cadwalader</u>		Address <u>Foppa Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis &amp; arterial insufficiency to legs</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1935</u> , to <u>present</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July</u> , 19 <u>59</u> , and that death occurred at <u>—</u> M., from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Ernest C. Brown Jr.</u>		ADDRESS (Street, city or town, state) <u>1104 N. Calvert St - 2</u>	
DATE SIGNED <u>July 17, '59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 20/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins &amp; Sons Co.</u>		ADDRESS <u>4905 York Road</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur R. Kline</u>	





TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7664

## CERTIFICATE OF DEATH

07642

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rossville		c. LENGTH OF STAY IN 1b X Rossville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 280 Ridge Rd.		d. STREET ADDRESS Box 280 Ridge Rd.	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Myrtle W. Mohr		4. DATE OF DEATH Month Day Year July 28, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1896
9. AGE (In years last birthday) yrs 63		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Robert Kuehne		14. MOTHER'S MAIDEN NAME Mary Hax	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. John Mohr		Address Box 280 Ridge Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> 44201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 1957, to July 28, 1959, that I last saw the deceased alive on July 28, 1959, and that death occurred at 12:25 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Louis Krause</u> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 1, 1959	
22c. NAME OF CEMETERY OR CREMATORY Zion Lutheran		22d. LOCATION (City, town, or county) (State) Stemmers Run, Balto. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home 7401 Belair Rd.		24a. REC'D BY REGISTRAR DATE AUG 3 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Krause			



7665

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN 1b <b>4 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>			
f. STREET ADDRESS <b>334 SOUTH NORRIS STREET</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>A</b> Last <b>MOLESWORTH</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>6</b> Year <b>1959</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-24-94</b>	
9. AGE (In years last birthday) <b>64</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Months Days Hours Min		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRUCK DRIVER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>MOTOR TRANSFER CO</b>			
11. BIRTHPLACE (State or foreign country) <b>MT AIRY MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>EDWARD M MOLESWORTH</b>				14. MOTHER'S MAIDEN NAME <b>LILLIE M RUNKLES</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>YES</b>				16. SOCIAL SECURITY NO. <b>218-14-8144</b>			
17. INFORMANT <b>CLIN REC VET ADM HOSP FT HOWARD MARYLAND</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <b>SHOCK, INTRACTABLE</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b). <b>CEREBRO-VASCULAR ACCIDENT</b> DUE TO (c). <b>UNKNOWN</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <b>PNEUMONIA - Duration unknown</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	
20f. (City or town) <b>VAH, Fort Howard, Md.</b>				20g. (County) <b>VAH, Fort Howard, Md.</b>		20h. (State) <b>VAH, Fort Howard, Md.</b>	
21. I certify that I attended the deceased from <b>July 2</b> , 19 <b>59</b> , to <b>July 6</b> , 19 <b>59</b> , and that death occurred at <b>5:45 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Armen Bogosian</b>				DATE SIGNED <b>7-6-59</b>			
PHYSICIAN'S NAME (Type) <b>Armen Bogosian</b>				M.D. <b>VAH, Fort Howard, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7/9/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>PROSPECT CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>FREDERICK COUNTY MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Olin Molesworth</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Krause</b>	

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07644

7666

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution - Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville 8, Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>10 Walker Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Morris</u> Middle <u>Pendleton</u> Last <u>Molesworth</u>				4. DATE OF DEATH Month <u>July</u> Day <u>6</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 3, 1905</u>	9. AGE (In years last birthday) yrs. <u>54</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>4</u> Hours <u>10</u> Min.	IF UNDER 24 HRS. Months <u>5</u> Days <u>4</u> Hours <u>10</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Automotive Electric Sales</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Sales</u>		11. BIRTHPLACE (State or foreign country) <u>Mt. Airey, Md.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>				13. FATHER'S NAME <u>Louis C. Molesworth</u>			
14. MOTHER'S MAIDEN NAME <u>Nellie Frances Gaber</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>216-07-1962</u>				17. INFORMANT <u>Mrs. Mildred C. Molesworth, 10 Walker Ave Pikesville 8, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>arterio-sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio-sclerosis</u> DUE TO (c) <u>arterio-sclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u> <u>8 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug 4</u> , 19 <u>40</u> to <u>July 6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 6</u> , 19 <u>59</u> , and that death occurred at <u>8:30</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1725 Rustington Rd. Pikesville 8, Md.</u> DATE SIGNED <u>July 7, 1959</u>							
ACTUAL SIGNATURE <u>John F. Williams</u> M.D.				PHYSICIAN'S NAME (Type) <u>Pikesville 8, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 9, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Memorials</u>		22d. LOCATION (City, town, or county) (State) <u>Linksbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank A. Menell</u>				24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>				DATE <u>JUL 10 '59</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7667

## CERTIFICATE OF DEATH

Reg. Dist. No. 07645

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>White Hall</b>		c. LENGTH OF STAY IN 1b <b>60 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Levina Ellen Moore</b>		4. DATE OF DEATH Month Day Year <b>July 6, 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 26, 1882</b>
9. AGE (In years last birthday) <b>76</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Wilkenville, S. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>J. Franklin Grant</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Elizabeth Davidson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>----</b>	
17. INFORMANT Address <b>Miss. Grace E. Moore White Hall, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hypertension Cordiac Phrombo</b> DUE TO (b) <b>2 days</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>b</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a m p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1950</b> to <b>July 5, 1959</b> that I last saw the deceased alive on <b>July 5, 1959</b> and that death occurred at <b>3:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>White Hall Md</b> DATE SIGNED <b>Milner Bortner</b>			
ACTUAL SIGNATURE <b>Milner Bortner</b>		PHYSICIAN'S NAME (Type) <b>Milner Bortner</b> <b>White Hall, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/8/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Bethel</b>	22d. LOCATION (City, town, or county) (State) <b>Madonna Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles C. Kurtz</b>		24a. REC'D BY REGISTRAR <b>Garrettsville, Md.</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>		DATE <b>JUL 10 '59</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7668

CERTIFICATE OF DEATH

Reg. Dist. No. 07646

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>				c. LENGTH OF STAY IN 1b <u>2 months, 17 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>				e. STREET ADDRESS <u>6612 Greig Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Patrick</u> Middle <u>Moore</u> Last <u>Moore</u>				4. DATE OF DEATH Month <u>7</u> Day <u>4</u> Year <u>19 59</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-16-59</u>	
9. AGE (In years last birthday) yrs. <u>3</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>17</u>		IF UNDER 24 HRS Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James R. Moore</u>				14. MOTHER'S MAIDEN NAME <u>Janet Frances Folks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>none</u>			
17. INFORMANT <u>Garnes Moore, father.</u>				Address <u>2-D.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hydrocephalus, unmarked with aspiration of stomach content</u> DUE TO (b) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>							
21. I certify that I attended the deceased from <u>19</u> to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>5:50 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>P. W. Rieckert</u> Pathologist				ADDRESS (Street, city or town, state) <u>4307 Mainfield Ave</u>			
PHYSICIAN'S NAME (Type) <u>P. W. Rieckert</u>				DATE SIGNED <u>Baltimore Md 7-4-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-9-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. H. Chambers</u>				ADDRESS <u>1114 St. John</u>		24a. REC'D BY REGISTRAR <u>JUL 10 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Charles S. Hanna</u>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7549

CERTIFICATE OF DEATH

07647

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk (22)</b>		c. LENGTH OF STAY IN 1b <b>15 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>38 Broadship Road</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>GRAHAM</b> Last <b>MORROW, Sr.</b>		4. DATE OF DEATH Month <b>July</b> Day <b>27</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 29, 1893</b>
9. AGE (In years last birthday) yrs <b>66</b>		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cannery</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>William Morrow</b>	
14. MOTHER'S MAIDEN NAME <b>Mary V. Ryle</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year and date of service) <b>Yes WW # I</b>	
16. SOCIAL SECURITY NO. <b>215-09-6260</b>		17. INFORMANT Address <b>Mr. John Morrow-1952 Wareham Rd. ( 22 )</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>177X DUE TO</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> (b) <b>CH of Prosthetic</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1-1</b> 19 <b>59</b> , to <b>7-27-59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7-27</b> 19 <b>59</b> , and that death occurred at <b>7 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>7/28/59</b>			
ACTUAL SIGNATURE <b>J.C. Collins, M.D.</b>		M.D. <b>2 Kinship Road- Baltimore 22, Md.</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 30, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Co. Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>WALTER BROOKS BRADLEY, INC. - DUNDALK</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 3 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7669 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07648

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5 Rognel Ave</u>		d. STREET ADDRESS <u>5 Rognel Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Howard W. Morsberger</u>		4. DATE OF DEATH Month Day Year <u>July 20, 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-4-1899</u>
9. AGE (In years last birthday) <u>60</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bar Tender</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Liquors</u>	11. BIRTHPLACE (State or foreign country) <u>MD</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Edward W. Morsberger</u>	
14. MOTHER'S MAIDEN NAME <u>Mary E. Espey</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>William F. Morsberger, Catonsville MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause lost. DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u>		DATE SIGNED <u>July 30, 1959</u>	
EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>8/1/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hoff + Son</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 3 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and if any event within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No. 07649

7670

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Phoenix</u>		c. LENGTH OF STAY IN 1b <u>43 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Phoenix Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Talmage</u> Middle <u>Mullen</u> Last <u>dore</u>		4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>22 June 1890</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u>	11. IF UNDER 24 HRS. Hours <u></u> Min <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	
11. BIRTHPLACE (State or foreign country) <u>Norristown, Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jefferson Mullen</u>		14. MOTHER'S MAIDEN NAME <u>Wright</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>1907-1911</u>		16. SOCIAL SECURITY NO. <u>218-01-507X</u>	
17. INFORMANT <u>Wife</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>primary site unknown</u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1953</u> , to <u>July</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10 July</u> , 19 <u>59</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter T. Kees</u> M.D.		ADDRESS (Street, city or town, state) <u>York Rd</u> DATE SIGNED <u>16 July 1959</u>	
PHYSICIAN'S NAME (Type) <u>Walter T. KEES</u>		<u>Cockeysville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-20-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Jessop Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>Sparks, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Brooks Funeral Service, Towson 4, Md.</u>		24a. REC'D BY REGISTRAR <u>JUL 21 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Charles P. Hines</u>	





TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7671

CERTIFICATE OF DEATH

Reg. Dist. No.

07650

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1500 Eastern Ave. Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Carolyn Amelia Nagengast</b>		4. DATE OF DEATH Month Day Year <b>July 7 19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 2, 1944</b>
9. AGE (In years last birthday) <b>14</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Joseph R. Nagengast</b>	
14. MOTHER'S MAIDEN NAME <b>Amelia Saint Cross</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Joseph R. Nagengast</b> Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> <b>1964</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Bone</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b> <b>15 mo.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 15</b> , 19 <b>59</b> , to <b>July 7</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>July 7</b> , 19 <b>59</b> , and that death occurred at <b>11:15A</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Joseph Miceli</b> M.D.		ADDRESS (Street, city or town, state) <b>108 S. Taylor Avenue</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Joseph Miceli, M.D.</b>		<b>Baltimore 21, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/10/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James Brudzinski</b> ADDRESS <b>1407 Eastern Ave. Rd.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 13 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>



7672

CERTIFICATE OF DEATH

Reg. Dist. No.

07652

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>MD.</b> c. COUNTY <b>BALTO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7209 WOODROW AVE</b>		d. STREET ADDRESS <b>7209 WOODROW AVE. (24)</b>	
3. NAME OF DECEASED (Type or print) <b>JOSEPH C NEUSCHAFER</b>		4. DATE OF DEATH <b>JULY 7 19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-5-1898</b>
9. AGE (In years last birthday) <b>61</b> yrs		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED (BANK)</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>JOHN NEUSCHAFER</b>		14. MOTHER'S MAIDEN NAME <b>MOLLIE BECK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>ELSIE NEUSCHAFER</b>		Address <b>7209 WOODROW AVE. (24)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DIABETES MELLITUS</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>10 MIN.</b> <b>15 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/10/57</b> , 19____, to <b>7/7/59</b> , 19____, that I last saw the deceased alive on <b>7/7/59</b> , 19____, and that death occurred at <b>11:50 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7422 Eastern Ave Md.</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Max Baun</b>		M.D. <b>7422 Eastern Ave</b>	
PHYSICIAN'S NAME (Type) <b>MAX BAUM</b>		<b>Baltimore Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>7-11-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ZION LUTHERAN</b>	22d. LOCATION (City town, or county) (State) <b>BALTO. CO. MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John S. Connelly</b>		ADDRESS <b>418 Eastern Blvd. (21)</b>	
24a. REC'D BY REGISTRAR <b>JUL 10 59</b>		24b. REGISTRAR'S SIGNATURE <b>Adrian J. ...</b>	

TO HOSPITAL—ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7673

### CERTIFICATE OF DEATH

07653

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTIMORE</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	c. LENGTH OF STAY IN <u>2 mon. 12 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE ST. HOSP.</u>		d. STREET ADDRESS <u>1928 W. Fayette St</u>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>MARGARET</u> Middle <u>COLLINS</u> Last <u>NICKLES</u>		<b>4. DATE OF DEATH</b> Month <u>July</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-23-94</u>
9. AGE (In years, last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Collie</u>		14. MOTHER'S MAIDEN NAME <u>Anna Kraft</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>  </u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>  </u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>  </u>	

<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infarctive myocardial fibrosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u> years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4/22/59</u> , 19 <u>  </u> , to <u>7/4/59</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>7/4/59</u> , 19 <u>  </u> , and that death occurred at <u>5</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Spring Grove St. Hosp.</u> DATE SIGNED <u>7-5-1959</u>		
ACTUAL SIGNATURE <u>Gertrude J. Fleischmann</u> M.D.		
PHYSICIAN'S NAME (Type) <u>GERTRUDE J FLEISCHMANN</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>  </u>	22b. DATE THEREOF <u>7-8-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MORCLAND PARK</u>
22d. LOCATION (City, town or county) <u>BALTO</u> (State) <u>MD</u>		24a. REC'D BY REGISTRAR <u>  </u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard Ruck</u> ADDRESS <u>5305 Harford</u>		24b. REGISTRAR'S SIGNATURE <u>  </u>

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4  
TO HOSPITAL: If the deceased is in the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

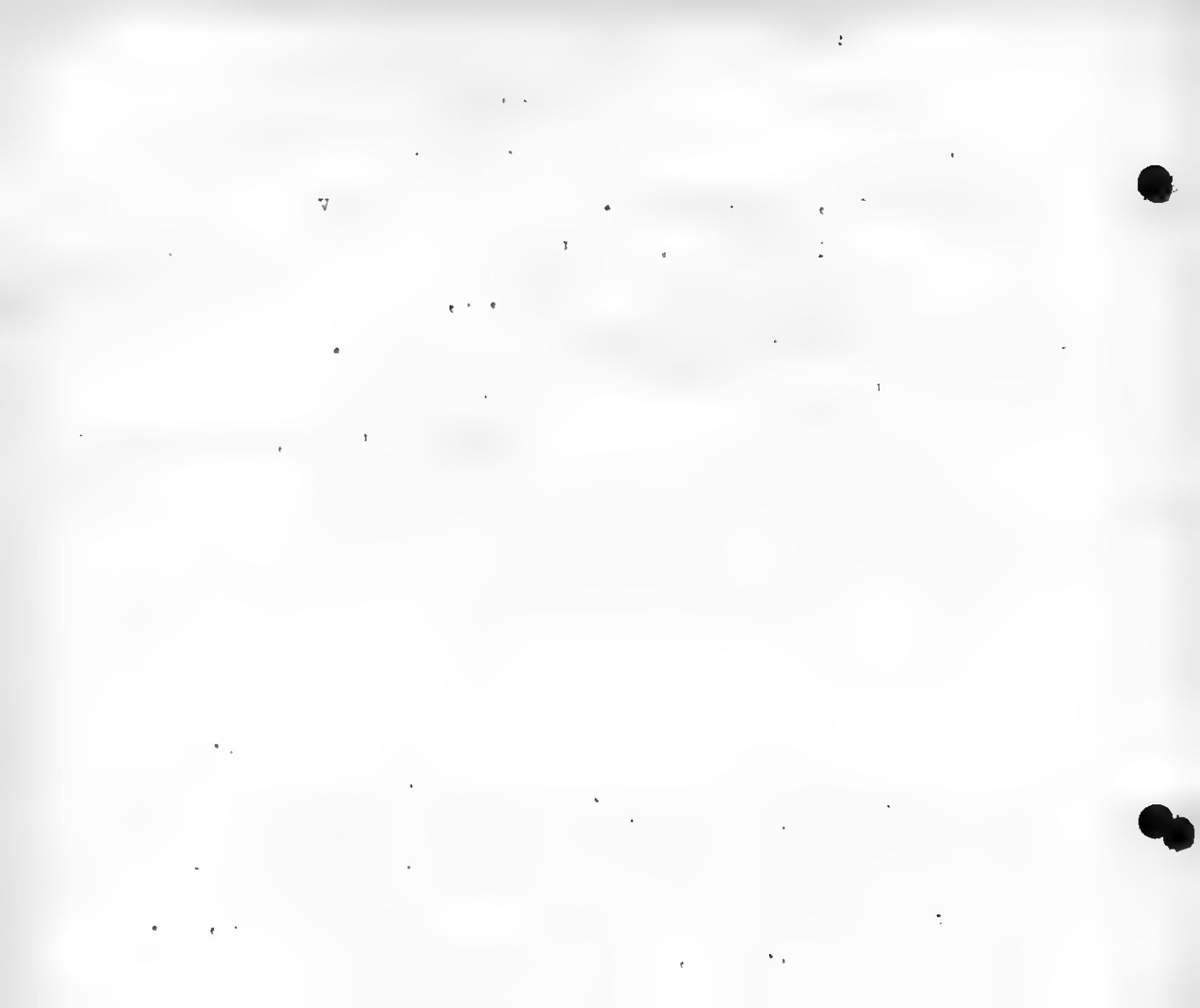
7674

## CERTIFICATE OF DEATH

07654

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in Pines, 16 Fusting Ave.</b>		d. STREET ADDRESS <b>407 Normandy Ave</b>	
3. NAME OF DECEASED (Type or print) First <b>Michael</b> Middle <b>J.</b> Last <b>O'Brien</b>		4. DATE OF DEATH Month <b>July</b> Day <b>7</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 5, 1874</b>
9. AGE (In years last birthday) <b>84</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
11. IF UNDER 24 HRS Months Days Hours Min		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Michael O'Brien</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Daly</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>Miss Veronica O'Brien, 407 Normandy Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA FACE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JAN. 1955</b> to <b>JUL 7, 1959</b> that I last saw the deceased alive on <b>7/7, 1959</b> , and that death occurred at <b>7 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3629 Edmondson Ave Baltimore, 29, Md.</b> DATE SIGNED <b>Arthur S. Hensley</b>			
ACTUAL SIGNATURE <b>Thos E Roach</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Thos E Roach</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 10/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore 29, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Nitzke Funeral Directors, 4101 Edmondson Ave</b>		24a. REC'D BY REGISTRAR <b>JUL 10 1959</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hensley</b>			





7675

## CERTIFICATE OF DEATH

07655

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Towson</b>				c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural Towson</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenarm Road</b>				/d. STREET ADDRESS <b>Glenarm Road</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sister Mary Ignace O'Mara</b>				4. DATE OF DEATH Month Day Year <b>July 27 1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 17, 1900</b>		9. AGE (In years last birthday) yrs. <b>59</b>	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RELIGIOUS.</b>		11. BIRTHPLACE (State or foreign country) <b>Short Hills New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph O'Mara</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Kehoe</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Sister M. Peter Fourier</b>		Address <b>Notch Cliff, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized cancer</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <b>Cancer of breast</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April</b> , 19 <b>59</b> , to <b>July</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>July 21</b> , 19 <b>59</b> , and that death occurred at <b>11:00A</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7501 York Road Towson 4, Md.</b> DATE SIGNED <b>7/28/59</b>							
ACTUAL SIGNATURE <i>Charles F. O'Donnell</i> M.D.							
PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell M.D.</b>							
22a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7-30-59.</b>		22c. NAME OF CEMETERY OR CREMATORY <b>VILLA MARIA CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>NOTCH CLIFF NR TOWSON, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles A. Geller</i> ADDRESS <b>9019 CONKLING ST. BALTO., 24, MD.</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 30 '59</b>		24b. REGISTRAR'S SIGNATURE <i>William P. ...</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



07656

VS A15 (4)  
ISM 9/58

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3 Melvin Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS <b>3 Melvin Ave</b>					
3. NAME OF DECEASED (Type or print) <b>Tillie Anna Paetow</b>		First Middle Last		4. DATE OF DEATH Month <b>7</b> Day <b>2--</b> Year <b>19 59</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-13-1872</b>		9. AGE (In years last birthday) <b>86</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Buyer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>Emil Paetow</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Schell</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>Frank Garich</b>		INFORMANT <b>Frank Garich</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		<b>Quinocular Fibrillation</b> <b>Cardio-Vascular Renal Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>8 yrs</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>3-14</b> 19 <b>51</b> to <b>7-2</b> 19 <b>59</b> that I last saw the deceased alive on <b>7-2</b> 19 <b>59</b> and that death occurred at <b>4 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>805 3rd. Ave. 28 Md</b>		DATE SIGNED <b>7-1-59</b>					
ACTUAL SIGNATURE <b>George E. Urban</b>		PHYSICIAN'S NAME (Type) <b>George E. Urban</b>							
22a. BURIAL, CREMATION, REINTERMENT (County) <b>Burial</b>		22b. DATE THEREOF <b>7-6-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mike Nuff &amp; Son</b>		ADDRESS <b>28</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Finner</b>			



7677

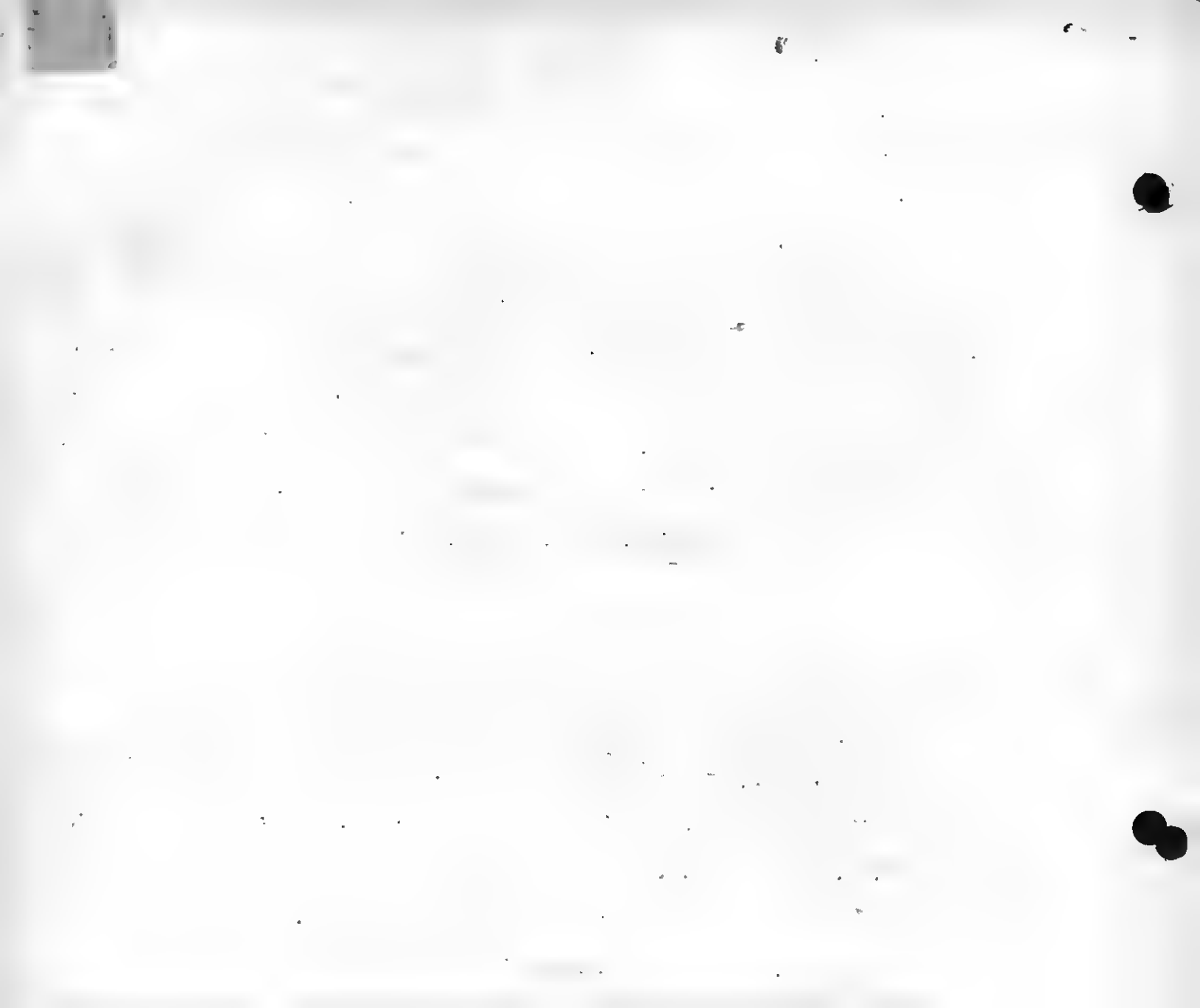
## CERTIFICATE OF DEATH

Reg. Dist. No. 07657

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN It <b>3 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. STREET ADDRESS <b>24 Clay Street</b>			
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>H</b> Last <b>PARKER</b>				4. DATE OF DEATH Month <b>July</b> Day <b>29</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 19, 1876</b>	
9. AGE (In years last birthday) yrs <b>83</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Naval Academy</b>		11. BIRTHPLACE (State or foreign country) <b>Annapolis, Maryland</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Charlotte MN: Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes SAW</b>				16. SOCIAL SECURITY NO <b>Informant</b> Address <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR ACCIDENT (CEREBRAL THROMBOSIS)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>ARTERIOSCLEROSIS, GENERALIZED</b> DUE TO (c) <b>UNKNOWN</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July 26</b> , 19 <b>59</b> , to <b>July 29</b> , 19 <b>59</b> , and that death occurred at <b>7:45 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>7/30/59</b> ACTUAL SIGNATURE <b>John W. Crawford</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b> PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b> <b>VAH, FORT HOWARD, MARYLAND</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-3-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Union Mt. Hall</b>		22d. LOCATION (City, town or county) (State) <b>Annapolis, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Reese Mortuary 108 W. Washington St. Annapolis, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 3 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Reese</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55

7550

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07658

1. PLACE OF DEATH o COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk (22)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk (22)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6826 Dunbar Road</b>		d. STREET ADDRESS <b>6826 Dunbar Road</b>	
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JOSEPH FRANK PAUKNER</b>		4. DATE OF DEATH Month <b>July</b> Day <b>30</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 27, 1895</b>
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Millwright Foreman-Steel</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pennsylvania</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Paukner</b>		14. MOTHER'S MAIDEN NAME <b>Maria (unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-07-0641</b>	
17. INFORMANT <b>Mrs. Robert Clark-3485</b>		Address <b>Dunhaven Rd. 22</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Arteriosclerotic Heart Disease</b> DUE TO <b>Life</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b> <b>8 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1, 1957</b> , to <b>July 30, 1959</b> , that I last saw the deceased alive on <b>July 24, 1957</b> , and that death occurred at <b>12:55 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7-31-59</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Eugene R. Evans</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Eugene R. Evans, M.D.</b>		<b>1 Liberty Parkway-Dundalk 22, Md.</b>	
22a. BURIAL, CREMATION, REBURY (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 3, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Co. Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradley, Inc., Dundalk</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 3 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			





TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. Page 4  
may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7678 CERTIFICATE OF DEATH

Reg. Dist. No. 07659

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>174 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>2769 /The Alameda</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>STEWART</b> Middle <b>O.</b> Last <b>PETERS</b>				4 DATE OF DEATH Month <b>July</b> Day <b>10</b> Year <b>1959</b>			
5 SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 25, 1895</b>	
9. AGE (In years last birthday) yrs <b>63</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Elevator</b>		11 BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12 CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Samuel Peters</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Meyers</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>WW I 217-09-8226</b>		17. INFORMANT Address <b>Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <b>EXCAVATING CARCINOMA, RIGHT UPPER LOBE, WITH SOLITARY METASTASIS TO LIVER.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b). DUE TO (c). PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)						INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
21. I certify that I attended the deceased from <b>January 17, 1959</b> , to <b>July 10, 1959</b> , that I last saw the deceased <b>alive on</b> , and that death occurred at <b>8:50 A.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>VAH, FORT HOWARD, MARYLAND 7/10/59</b>							
ACTUAL SIGNATURE <b>Donald D. Mark</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b>				PHYSICIAN'S NAME (Type) <b>DONALD D. MARK, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-14-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc.</b>				ADDRESS <b>6009 Harford Road, Baltimore 14, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 14 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Haines</b>			



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copies, papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7679

## CERTIFICATE OF DEATH

07660

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>80 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. STREET ADDRESS <b>1528 Druid Hill Avenue (17)</b>	
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>----</b> Last <b>PINN</b>		4. DATE OF DEATH Month <b>July</b> Day <b>12</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 28, 1893</b>
9. AGE (In years and birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>12</b> Hours <b>19</b> Min <b>59</b>	11. IF UNDER 24 HRS Months <b>6</b> Days <b>12</b> Hours <b>19</b> Min <b>59</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Metal Company</b>	
11. BIRTHPLACE (State or foreign country) <b>Warrenton, Virginia</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>Robert Pinn</b>		14. MOTHER'S MAIDEN NAME <b>Lena Campbell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>WW I 217-03-4616</b>	
17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Fort Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA OF RECTUM</b> <b>XXXX</b> CEREBROVASCULAR ACCIDENT (CLINICAL) Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 MONTHS</b> <b>3 MONTHS</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <b>a. m.</b> Month <b>19</b> Day <b>19</b> Year <b>1959</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 23</b> , 19 <b>59</b> , to <b>July 12</b> , 19 <b>59</b> , and that death occurred at <b>3:35 A. M.</b> , from the causes and on the date stated above. live on <b>July 12, 1959</b> ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>7/13/59</b>			
ACTUAL SIGNATURE <b>Thomas P. Cohan</b>		PHYSICIAN'S NAME (Type) <b>THOMAS P. CRAWAN, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/15/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S. Phillips</b>		ADDRESS <b>1808-10 N. Monroe St. Balto. 17, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUL 22 59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton L. Kraw</b>	



7680

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

07661

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills, Md.</b>		c. LENGTH OF STAY IN TB <b>23 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosewood State Training School</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Katherine</b> Middle <b>Rosalie</b> Last <b>Porter</b>		4. DATE OF DEATH Month <b>7</b> Day <b>22</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/28/23</b>
9. AGE (In years last birthday) <b>35</b> yrs		IF UNDER 1 YEAR Months <b>7</b> Days <b>22</b> Hours <b>19</b> Min <b>59</b>	IF UNDER 24 HRS Months <b>7</b> Days <b>22</b> Hours <b>19</b> Min <b>59</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry P. Porter - deceased</b>		14. MOTHER'S MAIDEN NAME <b>Ethel Grace Bailey - deceased</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Rosewood Records</b>		Address <b>---</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple pulmonary emboli</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Acute dysentery with colon perforation</b> DUE TO PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. <b>12:40</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>12:40 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4307 Ma-feld Ave, Balt-mo 14</b> DATE SIGNED <b>7/22/59</b>			
ACTUAL SIGNATURE <b>Det. W. Beeland Pathologist</b>		PHYSICIAN'S NAME (Type) <b>P. W. Rieckert</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/24/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Union Chapel Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Wilna, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Pickner &amp; Sons, No. 1 Pa. Ave., Balt., Md.</b>		24a. REC'D BY REGISTRAR <b>JUL 23 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7681 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07662

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>PARKTON</u> c. LENGTH OF STAY IN 1b <u>2 months</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PARKTON, MD.</u>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> d. STREET ADDRESS <u>108 E. CHESAPEAKE AVE</u> e. IS PES DECEASED ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MILTON H. POWELL</u>	4. DATE OF DEATH Month Day Year <u>7 4 1959</u>	5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 1915</u>	9. AGE (In years last birthday) <u>43</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM HAND</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	11. BIRTHPLACE (State or foreign country) <u>MD</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>ERNEST POWELL</u>	14. MOTHER'S MAIDEN NAME <u>SARAH DIGGS</u>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	16. SOCIAL SECURITY NO. <u>UNKNOWN</u>
17. INFORMANT <u>SARAH CAUSON</u>	Address <u>108 E. CHESAPEAKE AVE</u>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pushing Injuring &amp; Skull</u> Conditions, if any, which gave rise to immediate cause (b) <u>with Multiple</u> (c) <u>Fractures</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sitting on track when train passed</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Sitting on track when train passed</u>	20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)	21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>		
22a. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7/8/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>STEPHENSON CHAPEL</u>	22d. LOCATION (City, town, or county) (State) <u>SPARKS, BALTO. CO. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. I. Chatman Jr.</u>	24a. REC'D BY REGISTRAR <u>JUL 9 '59</u>	24b. REGISTRAR'S SIGNATURE <u>John A. Fennell</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death.





7682

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07663

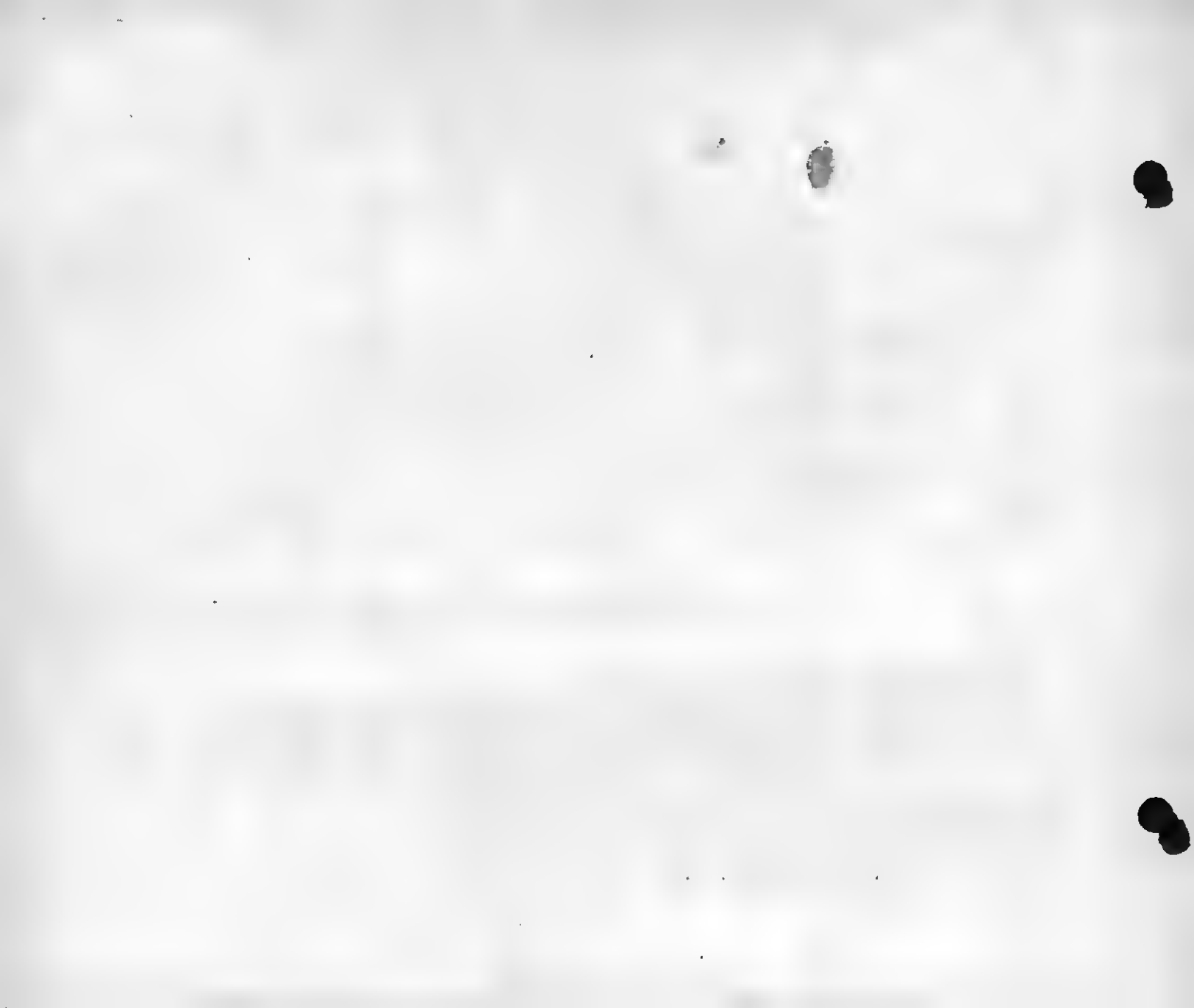
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point 19, Md.</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1317 N. Broadway Sparrows Pt.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTO.</b>	
d. STREET ADDRESS <b>1317 N. Broadway</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Pride</b> Last <b>Pride</b>		4. DATE OF DEATH Month <b>7</b> Day <b>10</b> Year <b>19 59</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/1/05</b>
9. AGE (In years last birthday) <b>54</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>10</b>	IF UNDER 24 HRS. Hours <b>14</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hot Blast Man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Ind.</b>	
11. BIRTHPLACE (State or foreign country) <b>Meklen Co. Vir.</b>		12. CITIZEN OF WHAT COUNTRY? <b>Am.</b>	
13. FATHER'S NAME <b>Samuel Pride</b>		14. MOTHER'S MAIDEN NAME <b>Beth Pride</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>227 10 2674</b>	
17. INFORMANT <b>Wife - 1317 N. Broadway</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rheumatic Carditis</b> <b>416X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>416X</b> (a), stating the underlying cause last. DUE TO (c) <b>416X</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>416X</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>	
20c. TIME OF INJURY Hour <b>19</b> Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>M. B. Davis</b>		DATE SIGNED <b>7-10-59</b>	
EXAMINER'S NAME (Type) <b>M. B. Davis, M. D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/14/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Carver Memorial Cem. Laurel Md.</b>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Theodore W. Long</b>		24a. REC'D BY REGISTRAR DATE <b>7/14/59</b>	
ADDRESS <b>2700 Edmondson Ave</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Kneave</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please state the cause of delay, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR FUNERAL PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

7683

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07664

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Overlea</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Overlea</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>5510 Kenwood Ave.</i>		e. STREET ADDRESS <i>5510 Kenwood Ave.</i>	
3. NAME OF DECEASED (Type or print) First <i>Ella</i> Middle <i>Nora</i> Last <i>Rauck</i>		4. DATE OF DEATH Month <i>7</i> Day <i>19</i> Year <i>59</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-20-1890</i>
9. AGE (In years last birthday) <i>69</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William Weaver</i>		14. MOTHER'S MAIDEN NAME <i>Lucy C. Myers</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>INFORMANT</i> <i>Carl E. Rauck</i> Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Occlusion</i> DUE TO (b) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO (c) <i>Diabetes Mellitus; Hemiplegia (left)</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes Mellitus; Hemiplegia (left)</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part of Part of item 10)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>April 14, 1958</i> to <i>July 19, 1959</i> that I last saw the deceased alive on <i>July 19, 1959</i> and that death occurred at <i>1:30 PM</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Samuel B. Wolfe</i> M.D.		ADDRESS (Street, city or town, state) <i>1331 E. North Ave. Balto City, Maryland</i>	
PHYSICIAN'S NAME (Type) <i>SAMUEL B. WOLFE</i>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7-23-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Rd.</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 22 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>			



ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

7684

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

07665

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>55 Towson</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>612 Dunkirk Rd.</i>		d. STREET ADDRESS <i>612 Dunkirk Rd.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Katherine</i> Middle <i>Rauschenbach</i> Last		4. DATE OF DEATH Month <i>July</i> Day <i>27</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-26-1883</i>
9. AGE (In years last birthday) <i>75</i>		IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Valentine Goeb</i>		14. MOTHER'S MAIDEN NAME <i>Caroline Kleper</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <i>216-10-8942</i>	
INFORMANT <i>John Rauschenbach</i> Address <i>same</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Esophagus</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <i>o m</i> <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>August 1959</i> to <i>July 1959</i> , that I lost saw the deceased alive on <i>July 27, 1959</i> , and that death occurred at <i>7:00 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W. M. Smith</i> M.D.		DATE SIGNED <i>August 1, 1959</i>	
PHYSICIAN'S NAME (Type) <i>W. M. Smith</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/30/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Hartford Rd.</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 28 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Ruck</i>	



7685

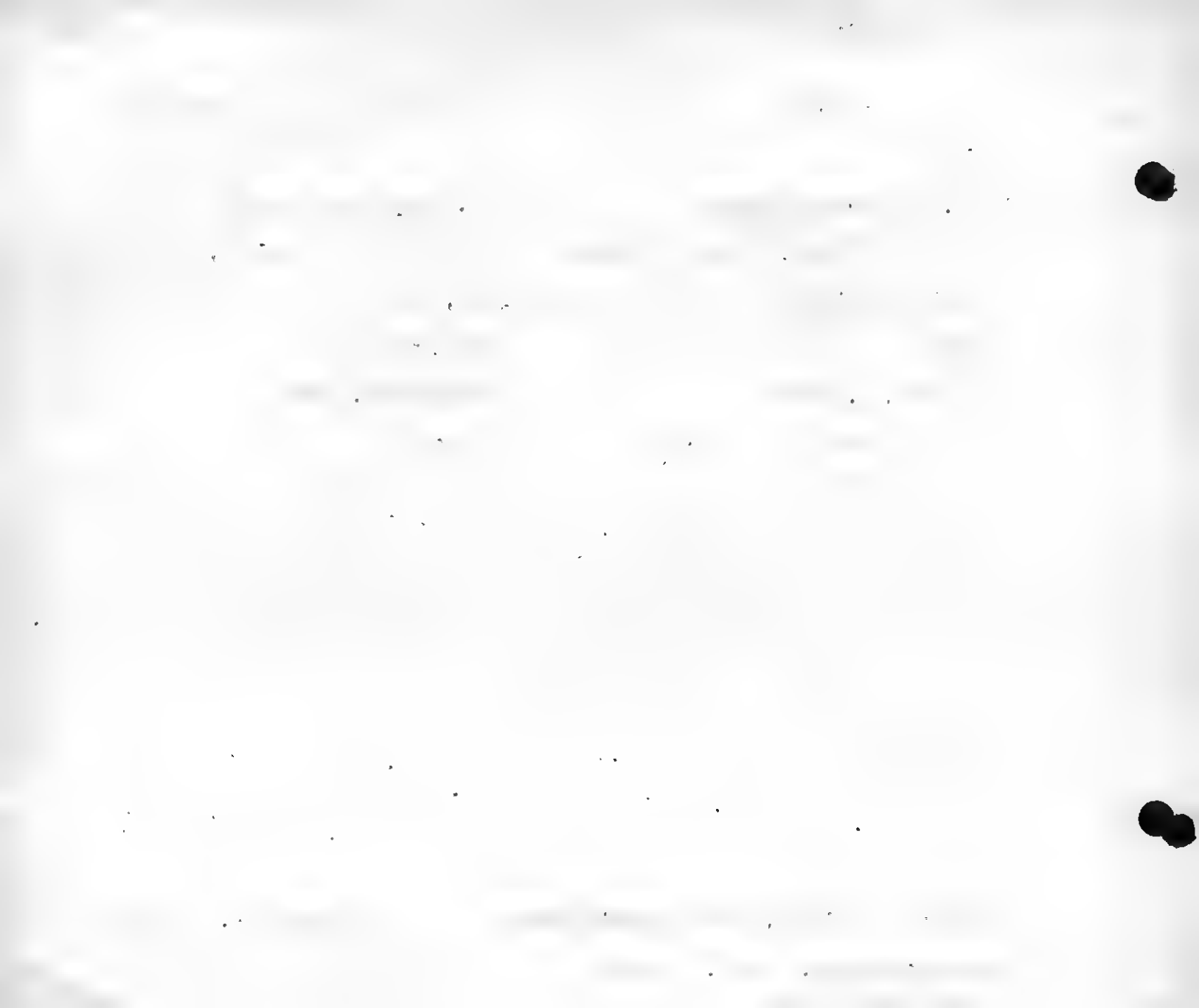
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07666

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>55 Towson</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>100 W. Susquehanna Avenue</b>		/d. STREET ADDRESS <b>100 W. Susquehanna Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>NELLIE DUNCAN RAWLINGS</b>		4. DATE OF DEATH Month Day Year <b>July 8, 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 17, 1874</b>
9. AGE (In years last birthday) <b>84</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John D. C. Duncan</b>		14. MOTHER'S MAIDEN NAME <b>Catherine E. Jones</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Family records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO <b>Arteriosclerosis Cerebral &amp; Heart with</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic</b> (c) <b>Chronic</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Chronic</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/8</b> , 19 <b>58</b> , to <b>7/8</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7/8</b> , 19 <b>59</b> , and that death occurred at <b>1207</b> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <b>Bennett A. Stoen M.D. 19 W. Seminary Ave. Baltimore 7/10/59</b>	
ACTUAL SIGNATURE <b>Bennett A. Stoen</b>		PHYSICIAN'S NAME (Type) <b>Bennett A. Stoen</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 11, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Jessop's Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Cockeysville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 14 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>





TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7688 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

Reg. Dist. No.

07667

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Dolfield Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Albert Redding</u>		4. DATE OF DEATH Month Day Year <u>July 31, 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 1, 1878</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tile &amp; Marble Setter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U S A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Frederick Redding</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Weaver</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-10-5765</u>	
17. INFORMANT <u>Vernon A. Redding</u>		Address <u>Owings Mills</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma - bladder</u> <u>181.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 1959</u> to <u>July 31, 1959</u> , that I last saw the deceased alive on <u>July 31, 1959</u> , and that death occurred at <u>6:30 AM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>James E. Williams</u> M.D. <u>Reisterstown, Maryland July 31, 1959</u> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug. 3, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's (Hampden)</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Burgee Funeral Home</u>		ADDRESS <u>3631 Falls Road</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7687

### CERTIFICATE OF DEATH

07668

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>13 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>RFD 2, Box 532</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>E.</b> Last <b>REDMOND</b>				4. DATE OF DEATH Month <b>July</b> Day <b>5</b> Year <b>59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 4, 1899</b>		9. AGE (In years last birthday) <b>60 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Taxi Cab</b>		11. BIRTHPLACE (State or foreign country) <b>St. Mary's Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>John F. Redmond</b>				14. MOTHER'S MAIDEN NAME <b>Ida Bond</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I 139-09-4797</b>		17. INFORMANT Address <b>Clin. Records. Vet. Adm. Hosp. Ft. Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ENLARGEMENT OF HEART WITH CONGESTIVE FAILURE</b> <b>527.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CYSTIC DISEASE OF LUNG</b> DUE TO (c) <b>PULMONARY EMPHYSEMA</b>							INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b> <b>UNKNOWN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 22</b> <b>1959</b> , to <b>July 5</b> <b>1959</b> , and that death occurred at <b>11:45 AM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Fort Howard, Md.</b> DATE SIGNED <b>7-5-59</b>							
ACTUAL SIGNATURE <i>George C. McElPatrick</i>		M.D. <b>Fort Howard, Md.</b>		DATE SIGNED <b>7/5/59</b>			
PHYSICIAN'S NAME (Type) <b>GEORGE C. McELPATRICK, M.D.</b>		<b>VAH, Fort Howard, Maryland</b>		<b>7/5/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>28 July 59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Singleton</i> <b>SINGLETON FUNERAL HOME, 200 Grain Highway</b>				24a. REC'D BY REGISTRAR <b>JUL 8 59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knap</i>	
<b>Glen Burnie, Md.</b>							



7689

CERTIFICATE OF DEATH

Reg. Dist. No.

07669

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charmelle</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charmelle</u>	
c. LENGTH OF STAY IN 1b <u>4 1/2 yrs</u>		d. STREET ADDRESS <u>502 Charmelle Rd</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>at home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Hazel</u> Middle <u>Michael</u> Last <u>Reid</u>		4. DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 10 1890</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Mins. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Charmelle Rd</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas Michael</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Frost</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Wife</u>		Address <u>502 Charmelle Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rheumatic Heart Disease —</u> DUE TO <u>Mitral Stenosis and Drufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic urinary tract infection</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1947</u> , 19 <u>—</u> , to <u>711</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/30</u> , 19 <u>59</u> , and that death occurred at <u>5:20 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>11 E. Chase St Baltimore 2 Md</u> DATE SIGNED <u>7/2/59</u>			
ACTUAL SIGNATURE <u>Martin T. Singewald</u> M.D.			
PHYSICIAN'S NAME (Type) <u>MARTIN T. SINGEWALD M.D.</u>			
22a. BURIAL, CREMATION REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>July 3/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>	22d. LOCATION (City, town or county) (State) <u>Baltimore 2 Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William J. Hume</u>		24. REC'D BY REGISTRAR <u>—</u> 24b. REGISTRAR'S SIGNATURE <u>—</u>	
24c. DATE <u>JUL 6 '59</u>			



TO HOSPITAL - ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										07670	
7689										CERTIFICATE OF DEATH	
Reg. Dist. No.											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admision) a. STATE <u>Maryland</u> b. COUNTY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			c. LENGTH OF STAY IN 1b <u>2yr2mth9dys</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>					d. STREET ADDRESS <u>5506 Rubin Avenue</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Aaron</u> Last <u>Rettman</u>					4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>19 59</u>						
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>1876</u>		9. AGE (In years last birthday) <u>82</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>cooperage business</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Retail</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>			12. CITIZEN OF WHAT COUNTRY? <u>Russia</u>			
13. FATHER'S NAME <u>Unknown</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>			16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mid-thigh amputation of left extremity on 7-8-59 due to arteriosclerotic</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>gangrene</u>								
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>SPRING GROVE STATE HOSPITAL</u>		(County) (State)		
21. I certify that I attended the deceased from <u>May 3</u> , 19 <u>57</u> , to <u>July 12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 12</u> , 19 <u>59</u> , and that death occurred at <u>11:45 PM</u> , from the causes and on the date stated above.											
ACTUAL SIGNATURE <u>Stella Wachslar</u>			M.D. <u>SPRING GROVE STATE HOSPITAL</u>			DATE SIGNED <u>7-13-59</u>					
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>			<u>Catonsville 28, Maryland</u>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>July 14/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Shelton Zion</u>			22d. LOCATION (City, town, or county) (State) <u>Wheatdale, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sol Johnson</u>					ADDRESS <u>1124-26 N. North Ave</u>		24a. REC'D BY REGISTRAR <u>JUL 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. House</u>		





07671

# CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> d. STREET ADDRESS <u>3219 Hiss Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mr. William J. Reuschling</u> First Middle Last 4. DATE OF DEATH <u>July 14, 1959</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>3-19-1901</u> 9. AGE (In years last birthday) <u>58</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min IF UNDER 24 HRS: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Gas &amp; Elec. Co.</u> 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William J. Reuschling</u> 14. MOTHER'S MAIDEN NAME <u>Clara Tillman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>Informant</u> 17. ADDRESS <u>Mrs Clara Reuschling same</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cholangiocarcinoma</u> DUE TO (b) <u>15</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>DUE TO</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19</u> WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>6217 Harford Rd Baltimore</u> 20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>January 17, 1950</u> , to <u>July 14, 1959</u> , that I last saw the deceased alive on <u>July 14, 1959</u> , and that death occurred at <u>7:15 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6217 Harford Rd Baltimore</u> DATE SIGNED <u>7/14/59</u> ACTUAL SIGNATURE <u>E. J. J. J. J.</u> M.D. <u>E. J. J. J. J.</u> PHYSICIAN'S NAME (Type) <u>E. J. J. J. J.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>7-17-59</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem.</u> 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Rd.</u> 24a. REC'D BY REGISTRAR <u>JUL 16 1959</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneel</u>	



7691

## CERTIFICATE OF DEATH

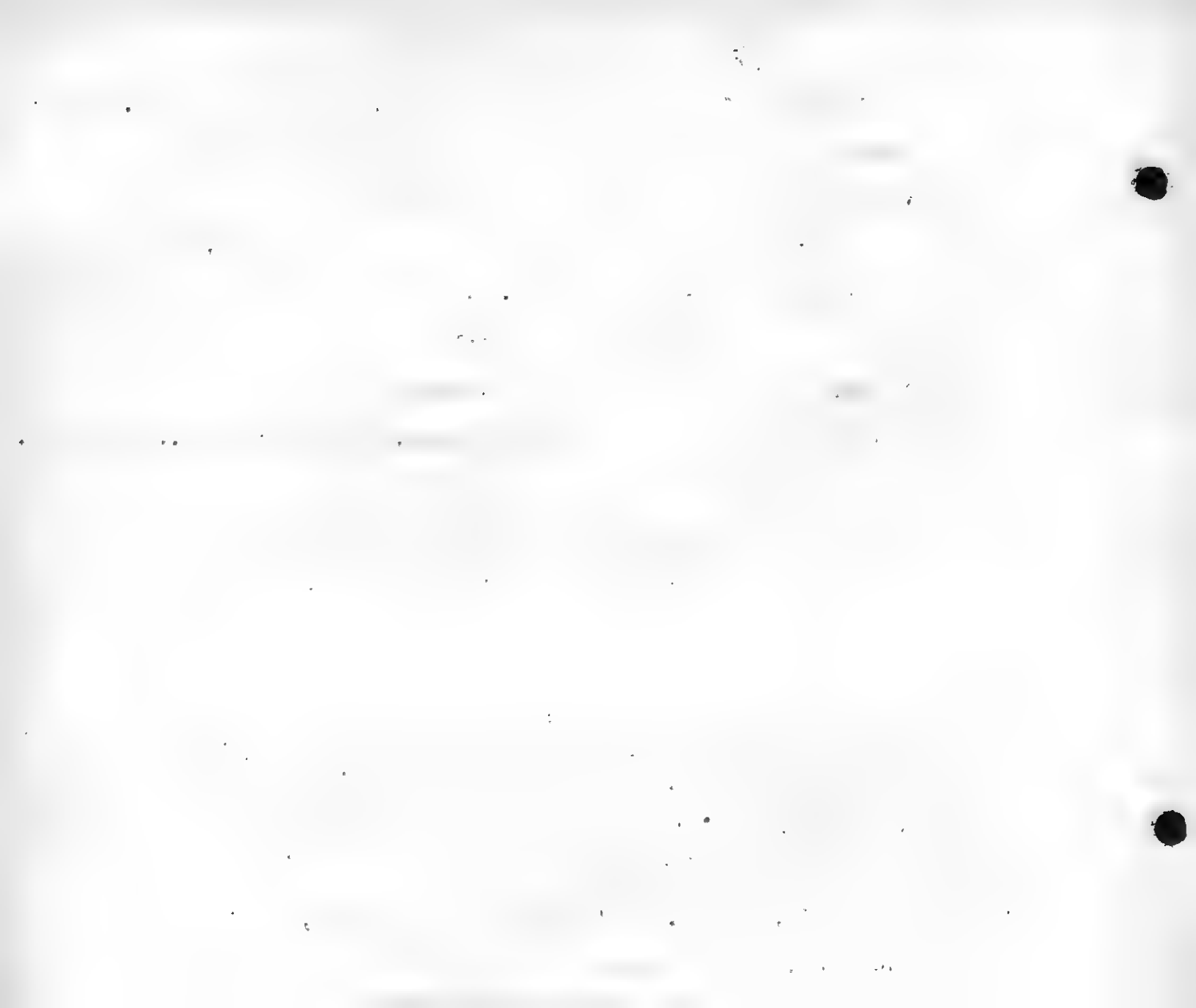
07672

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New York</b> b. COUNTY <b>Queens Borough</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jackson Heights</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>311 Ivy Church Road</b>		d. STREET ADDRESS <b>3446 91st Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>RUBINO</b> Last		4. DATE OF DEATH Month <b>July</b> Day <b>11</b> , Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 1, 1875</b>
9. AGE (In years, month, days) <b>83</b> yrs		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Michael Pietro</b>		14. MOTHER'S MAIDEN NAME <b>Vincenza Pietro</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Anthony Rubino, 311 Ivy Church Rd., Towson, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO <b>Hypertensive C.V. disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 1959</b> to <b>July 1959</b> that I last saw the deceased alive on <b>July 10th 1959</b> and that death occurred at <b>22nd Street</b> from the causes and on the date stated above.		ADDRESS (Street city or town state) DATE SIGNED <b>7/11/59</b>	
ACTUAL SIGNATURE <b>David J. Roth Jr. M.D.</b>		M.D. <b>8402 Broadway - 4</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 15, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Queens, New York</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Maryland</b>		24a. REC'D BY REGISTRAR <b>DATE JUL 17 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

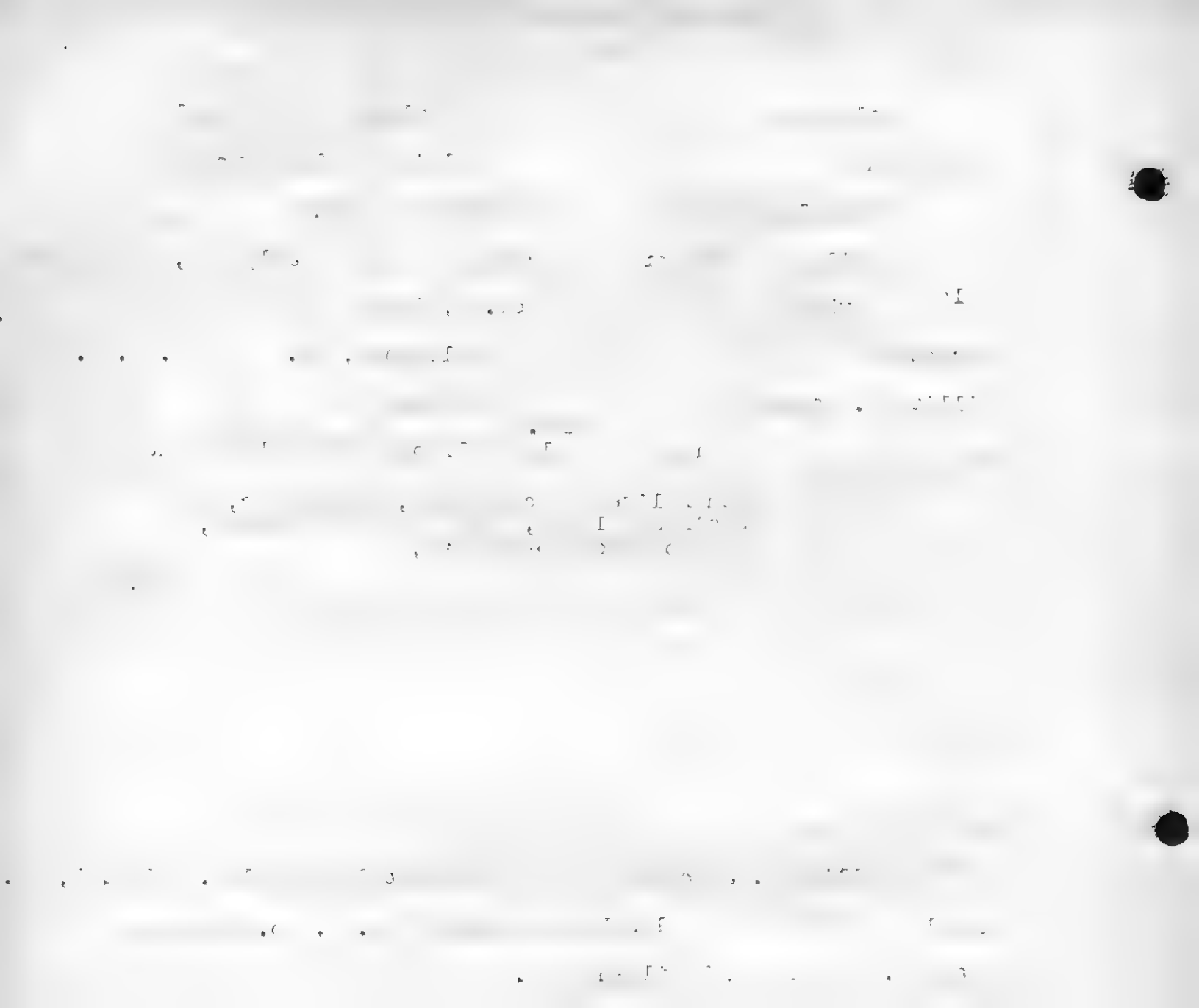
7556

## CERTIFICATE OF DEATH

Reg. Dist. No.

07673

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lansdowne</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore (Lansdowne)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>358 Bigley Avenue</b>		d. STREET ADDRESS <b>358 Bigley Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Emily Baugher Rucker</b>		4. DATE OF DEATH Month Day Year <b>July 13, 19 59</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 4, 1894</b>
9. AGE (In years last birthday) <b>64</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William R. Baugher</b>		14. MOTHER'S MAIDEN NAME <b>Ida Lewis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Alice Elliott</b>		Address <b>358 Bigley Avenue #27</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized sarcomatosis, metastatic, to</b> DUE TO <b>brain and lungs, with right hemiplegia,</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>due to sarcom of uterus,</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>a short time</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 19 1959</b> to <b>July 13 1959</b> that I last saw the deceased alive on <b>July 13 1959</b> and that death occurred at <b>6:00</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>William R. Johnson</b> <b>403 Medical Arts Bldg. Balto. 1, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/15/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>A. A. Co. Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 15 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneiss</b>			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7692

## CERTIFICATE OF DEATH

Reg. Dist. No.

07674

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>				c. LENGTH OF STAY IN 1b <u>1yr 1mth 22days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Parkville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				d. STREET ADDRESS <u>11805 Wilson Point Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>Agnes</u> Last <u>Sager</u>				4. DATE OF DEATH Month <u>July</u> Day <u>15</u> Year <u>1959</u>					
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 28, 1886</u>			
9. AGE (In years and birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>		IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>									
13. FATHER'S NAME <u>Franklin Pilling</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Beans</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis.</u> DUE TO (c) <u>  </u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> Month <u>  </u> Day <u>  </u> Year <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				(County)		(State)			
21. I certify that I attended the deceased from <u>May 5</u> , 19 <u>59</u> , to <u>July 15</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 15</u> , 19 <u>59</u> , and that death occurred at <u>12:30</u> M., from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Stella Wachslar</u> M.D.				ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u>					
DATE SIGNED <u>7-15-59</u>									
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>				<u>Catonville 28, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-17-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>				ADDRESS <u>5305 Harford Rd.</u>		24a. REC'D BY REGISTRAR <u>Jul 24 1959</u>			
24b. REGISTRAR'S SIGNATURE <u>Jul 24 1959</u>				24c. REGISTRAR'S SIGNATURE <u>Jul 24 1959</u>					





7693

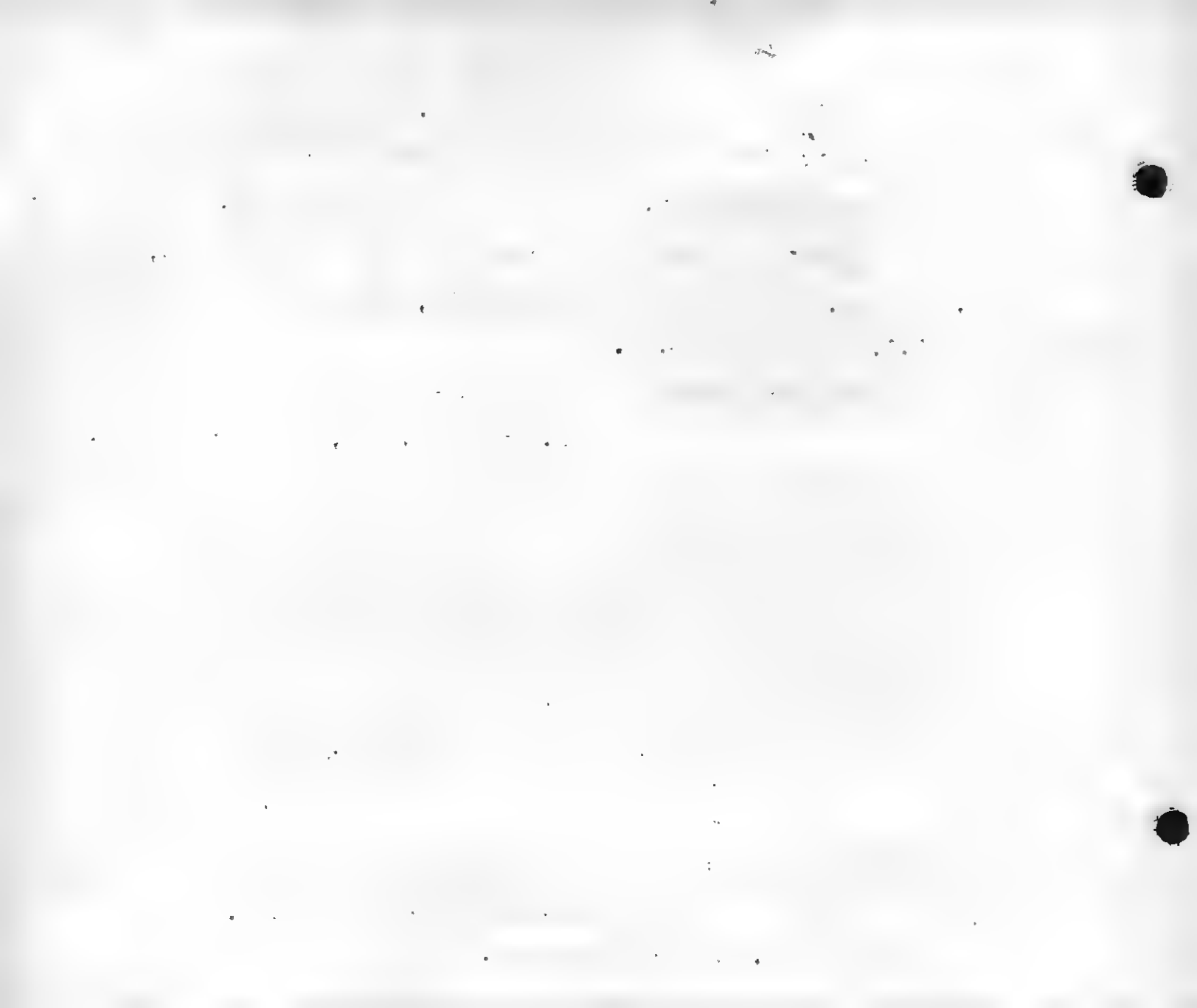
CERTIFICATE OF DEATH

07675

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>115 Fairfield Dr.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <b>Lydia Mary Sapp</b>				4. DATE OF DEATH Month Day Year <b>July 18, 19 59</b>			
5 SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 14, 1873</b>	9. AGE (In years last birthday) <b>86</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>O.H.</b>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Christian Heisler</b>				14. MOTHER'S MAIDEN NAME <b>Eva -----</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown, If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT Address <b>Mr. Francis H. Sapp, 115 Fairfield Dr.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis C.V.D.</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 14, 19 59</b> to <b>July 18, 19 59</b> that I last saw the deceased alive on <b>July 14, 19 59</b> , and that death occurred at <b>5 PM</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>3325 Frederick Ave Balto Md</b>				DATE SIGNED			
ACTUAL SIGNATURE <b>J. C. Pound</b> M.D.							
PHYSICIAN'S NAME (Type) <b>J. C. Pound</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/21/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Dir. 4101 Edmondson Ave.</b> ADDRESS				24a. REC'D BY REGISTRAR DATE <b>JUL 21 '59</b>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.



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## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

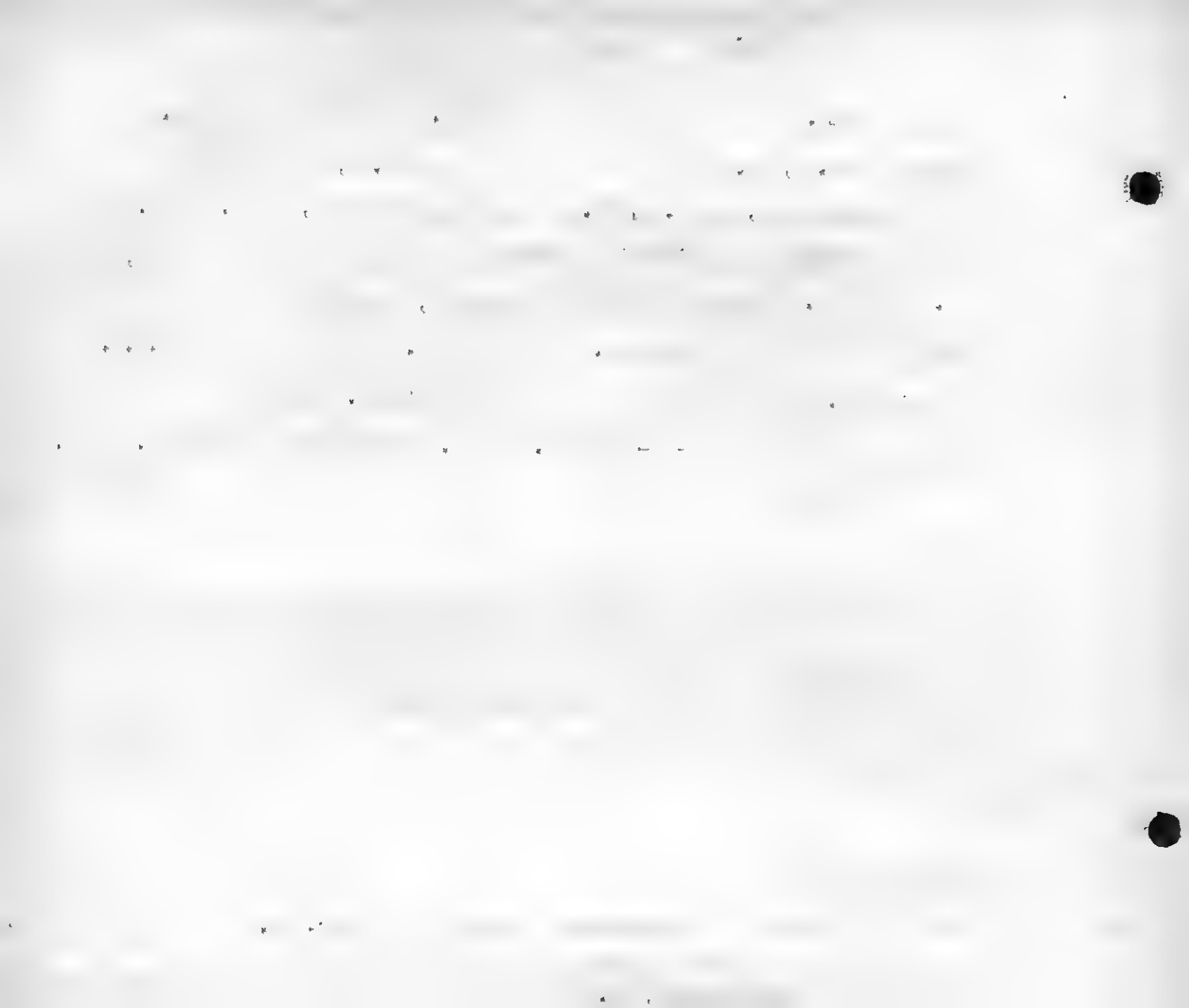
7694

## CERTIFICATE OF DEATH

07676

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockdale Balto. 7, Md.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balto. 7.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3616 Langrehr Road, Balto. 7, Md.</b>				d. STREET ADDRESS <b>3616 Langrehr Road, Balto. 7, Md.</b>			
3. NAME OF DECEASED (Type or print) First <b>Audrey</b> Middle <b>Christinia</b> Last <b>Schmauch</b>				4. DATE OF DEATH Month <b>July</b> Day <b>12</b> Year <b>19 59</b>			
5. SEX <b>F.</b>		6. COLOR OR RACE <b>W.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>August 12, 1915</b>	
9. AGE (In years last birthday) yrs. <b>43</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Life Ins.</b>		11. BIRTHPLACE (State or foreign country) <b>Balto.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Philip F. Airey</b>				14. MOTHER'S MAIDEN NAME <b>Catherine E. Brown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-03-5712</b>		17. INFORMANT <b>Mr. Adam A. Schmauch 3616 Langrehr Rd. Balto. 7.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>metastatic carcinoma of Rectum.</b> <b>154X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>p. m.</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <b>July 13, 1959</b> , to <b>July 13, 1959</b> , that I last saw the deceased alive on <b>July 13, 1959</b> , and that death occurred at <b>12:45 P.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>8627 Liberty Rd. Randallstown, Md.</b> DATE SIGNED <b>7/13/59</b>							
ACTUAL SIGNATURE <b>M. J. Ellis</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Morton J. Ellis</b>							
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/15/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Loring Byers</b>				ADDRESS <b>8728 Liberty Road</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 21 '59</b>	
						24b. REGISTRAR'S SIGNATURE <b>A. Charles E. Kline</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7695

## CERTIFICATE OF DEATH

Reg. Dist. No. 07677

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>3 Vol-4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2734 Harford Ave Balto 18, md</u>	
c. LENGTH OF STAY IN 1b <u>3 YEARS</u>		d. STREET ADDRESS <u>329 Harford Ave</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvin Ridge Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Katherine</u> Last <u>Schmidt</u>		4. DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 20, 1866</u>
9. AGE (In years last birthday) <u>93</u> yrs		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Germany</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>J. HENRY KABERNAGEL</u>		14. MOTHER'S MAIDEN NAME <u>805 FREDRICK ROAD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>NONE</u>	
17. INFORMANT <u>CAPT. ALFRED W. KABERNAGEL</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right lobar pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Spending Oxygen unknown</u>		(c) <u>Cardiac failure Left</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardiac failure Left</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> a. m. <u>19</u> p. m.	
20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>for</u> <u>1919</u> to <u>7/1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/30</u> , 19 <u>59</u> , and that death occurred at <u>6:20 A.M.</u> from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Cliff Ratliff, Jr.</u> M.D. <u>4605 EDMONDSON AVE</u>		DATE SIGNED <u>7/1/59</u>	
PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF, JR.</u>		<u>BALTIMORE 29, md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7/3/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LODNON PARK CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HENRY SANDER &amp; SONS INC. BALTO. MD.</u>		24a. REC'D BY REGISTRAR <u>JUL 6 59</u>	24b. REGISTRAR'S SIGNATURE <u>Cliff R. Ratliff</u>

Sanders Funeral Parlor Broadway & North Ave

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7696

## CERTIFICATE OF DEATH

Reg. Dist. No. 07678

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pikesville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pikesville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3222 Smith Avenue</i>		d. STREET ADDRESS <i>3222 Smith Avenue</i>	
3. NAME OF DECEASED (Type or print) <i>Lucille Anne Schuman</i>		4. DATE OF DEATH <i>July 21 1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 11, 1914</i>
9. AGE (in years last birthday) <i>44</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	
11. BIRTHPLACE (State or foreign country) <i>Brooklyn, N. Y.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Late Charles Gararelli</i>		14. MOTHER'S MAIDEN NAME <i>Anna</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO	
17. INFORMANT <i>M. J. Harold Schuman - 3222 Smith Ave</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary occlusion</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Rheumatic Cardiovascular disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 min</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>none</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan 1954</i> to <i>7/21 1959</i> that I last saw the deceased alive on <i>7/20 1959</i> , and that death occurred at <i>9 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>D. Maurice Feldman M.D.</i>		ADDRESS (Street, city or town, state) <i>2 E Read St.</i> DATE SIGNED <i>7/22/59</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>July 23/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Chesapeake Amuro</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Sol Lewman + Bur</i> ADDRESS <i>- 1124-26 W. North Ave</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 24 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna.</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

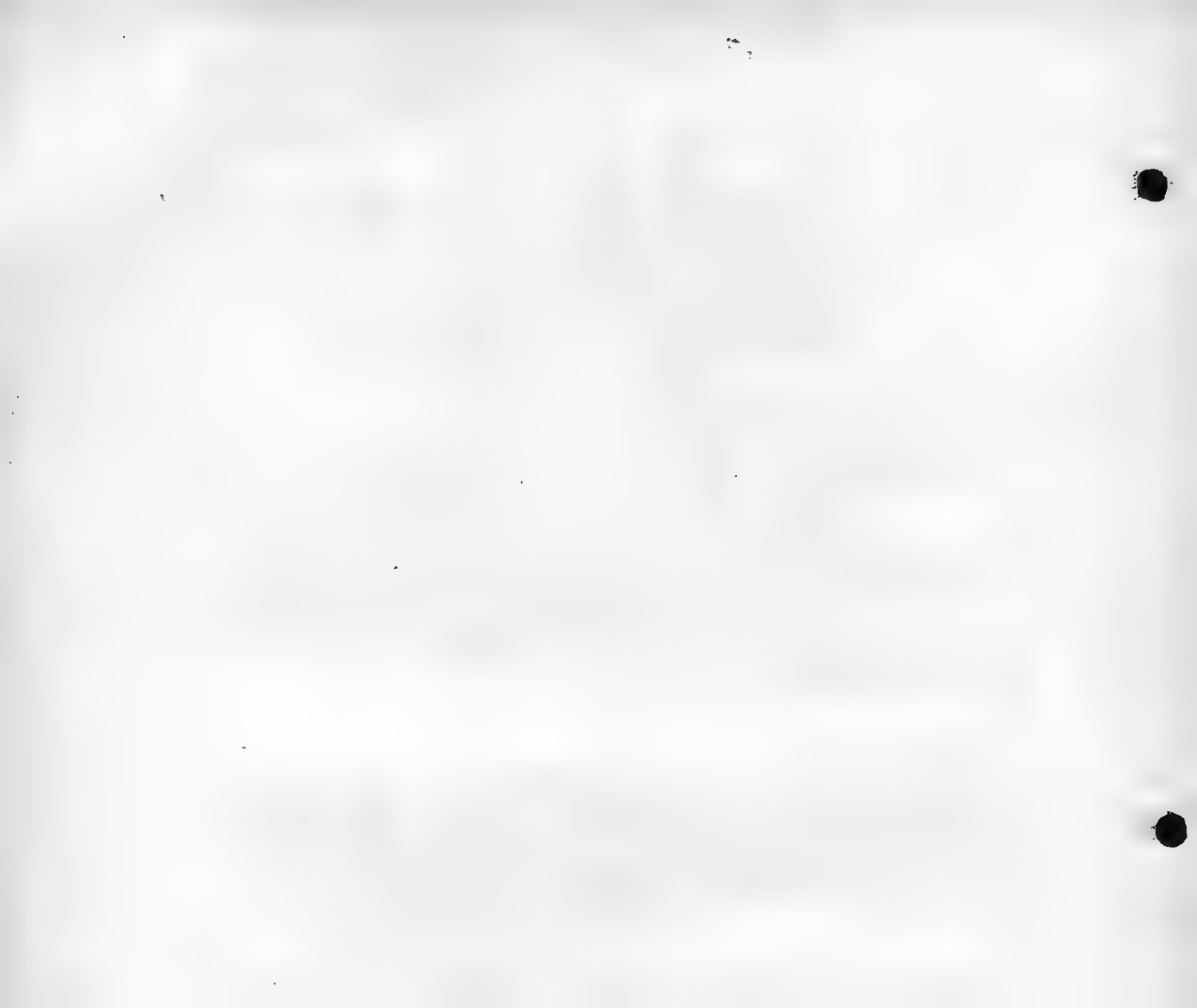
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7697 Item 8 Film G245 7-29-59 et  
CERTIFICATE OF DEATH

Reg. Dist. No.

07679

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kenwood Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kenwood Park Fullerton</u>	
c. LENGTH OF STAY IN 1b <u>21 yrs</u>		d. STREET ADDRESS <u>5231 Trumps Mill Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5231 Trumps Mill Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Robert</u> Last <u>Schuster</u>		4. DATE OF DEATH Month <u>July</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 7 1880</u>
9. AGE (In years last birthday) <u>78</u> yrs		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>13</u> Hours <u>15</u> Min <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FREDERICK Schuster</u>		14. MOTHER'S MAIDEN NAME <u>GESEINE BORCHERS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Anna B. Schuster</u>		Address <u>5231 Trumps Mill Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prostatic Cancer</u> 177X DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anemia, secondary to endogenous malnutrition.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Spring</u> , 1957, to <u>7-20</u> , 1959, that I last saw the deceased alive on <u>3pm 7-22</u> , 1959, and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above			
ACTUAL SIGNATURE <u>John C. Hyle</u> M.D.		ADDRESS (Street, city or town, state) <u>7577 Belair Rd</u> DATE SIGNED <u>7-21-59</u>	
PHYSICIAN'S NAME (Type) <u>JOHN C. Hyle</u>		<u>Ballo Gma</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JULY 23 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE PARK CEM</u>	22d. LOCATION (City, town, or county) (State) <u>WOODLAWN MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Duffel Bros 7110 Belair Road.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 23 '59</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiana</u>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7698

## CERTIFICATE OF DEATH

07680

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>BALTO. 13</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural: Towson</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Budwood Sanatorium Towson 4, Maryland</b>				d. STREET ADDRESS <b>3517 Pelham Avenue</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Kela MARY Scilipote</b>				4. DATE OF DEATH Month <b>July</b> Day <b>9</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-18-14</b>	
9. AGE (In years lost birthday) <b>44</b> yrs		10. UNDER 1 YEAR <b>+</b> Months		11. UNDER 24 HRS. <b>+</b> Days		12. Hours <b>+</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Boston, Pa</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>James Smith</b>				14. MOTHER'S MAIDEN NAME <b>Hazel Derringer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>			
17. INFORMANT <b>Personal History</b>				Address <b>Hospital Records, Budwood Sanatorium</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <del>STATE DEATH</del> <b>Pulmonary Edema</b> INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b>							
DUE TO (b) <b>Myocardial Hypertrophy &amp; 5 yrs</b>							
DUE TO (c) <b>Decompensation Chronic Pulmonary Fibrosis, Tuberculosis 10 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>9/25</b> 19 <b>59</b> to <b>7/9</b> 19 <b>59</b> , that I last saw the deceased alive on <b>7/9</b> 19 <b>59</b> , and that death occurred at <b>1:25 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Milton B. Kress</b> M.D.				ADDRESS (Street, city or town, state) <b>Budwood Sanatorium, Towson 4, Md.</b>			
DATE SIGNED							
PHYSICIAN'S NAME (Type) <b>Milton B. Kress, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>BURIAL</b>		<b>7/13/59</b>		<b>PARKWOOD Cem.</b>		<b>BALTIMORE, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LEONARD J. Ruck</b>				ADDRESS <b>5305 HARFORD RD</b>			
24a. REC'D BY REGISTRAR <b>JUL 13 '59</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kress</b>			

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7699

CERTIFICATE OF DEATH

Reg. Dist. No. 07681

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glyndon</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Glyndon</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>19 Butler Road</b>				d. STREET ADDRESS <b>19 Butler Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>W.</b> Last <b>Seabold</b>				4. DATE OF DEATH Month <b>July</b> Day <b>5</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 1, 1878</b>	
9. AGE (In years last birthday) yrs <b>81</b>		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) <b>Baltimore City</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Asst. Chief clerk at B&amp;O R.R.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore City</b>			
13. FATHER'S NAME <b>Charles A. Seabold</b>				14. MOTHER'S MAIDEN NAME <b>Minnie F. Flaggs</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>705-12-1490</b>		17. INFORMANT Address <b>Dr. William Seabold Glyndon, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema and uremia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Hypertrophy of prostate gland</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertrophy of prostate gland</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 12</b> , 19 <b>41</b> to <b>7-4-59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>July 4</b> , 19 <b>59</b> , and that death occurred at <b>8 A.</b> M., from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>23 Hanover Road</b> DATE SIGNED <b>Reisterstown, Md.</b>							
ACTUAL SIGNATURE <b>S. Walter Landau</b>		M.D. <b>Reisterstown, Md.</b>					
PHYSICIAN'S NAME (Type) <b>S. Walter Landau, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 8, 59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Eline &amp; Sons</b>				ADDRESS <b>Reisterstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 9 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7700

## CERTIFICATE OF DEATH

Reg. Dist. No. 07682

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>9mth8dys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>2918 Presstman Street #16</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>XX R.</b> Last <b>Serio</b>				4. DATE OF DEATH Month <b>July</b> Day <b>31</b> Year <b>19 59</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. <del>MARRIED</del> <input checked="" type="checkbox"/> <del>NEVER MARRIED</del> <input checked="" type="checkbox"/> <del>WIDOWED</del> <input type="checkbox"/> <del>XXXXXXXXXX</del>		8. DATE OF BIRTH <b>5, 1889</b> <b>Dec. XXX1889</b>	
9. AGE (In years last birthday) <b>69</b>		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Italy</b>	
12. CITIZEN OF WHAT COUNTRY <b>Italy</b> ✓							
13. FATHER'S NAME <b>Joseph Serio</b>				14. MOTHER'S MAIDEN NAME <b>Concetta Giglio</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>XXXXXXXXXX</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <b>None XXXXXXXX</b>		17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Inevitable diabetic coma.</b> <b>DOUX</b> DUE TO <b>CVA. (cerebral vascular accident).</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Oct. 23, 1958</b> to <b>7/31/59</b> , that I last saw the deceased alive on <b>7/31/59</b> , and that death occurred at <b>11:30 PM</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>7/31/59</b>							
ACTUAL SIGNATURE <b>Bruno Radauskas</b> M.D.				PHYSICIAN'S NAME (Type) <b>BRUNO RADAUSKAS</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>8/4/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. ...</b>				ADDRESS <b>118 S. ...</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 3 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Robert S. ...</b>							

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7701

## CERTIFICATE OF DEATH

Reg. Dist. No.

07683

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>2 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Paradise Nursing Home</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville Baltimore</b>	
3. NAME OF DECEASED (Type or print) First <b>Nellie</b> Middle <b>A.</b> Last <b>Sheets</b>		4. DATE OF DEATH Month <b>July</b> Day <b>13</b> Year <b>1959</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. <del>MARRIED</del> <b>WIDOWED</b>	8. DATE OF BIRTH <b>July 12, 1873</b>
9. AGE (In years last birthday) yrs <b>86</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-10-1544</b>	
17. INFORMANT <b>Mrs. Evelyn Andersen</b>		Address <b>2708 Oswego Ave, Balto. D</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Degenerative Heart Disease</b> DUE TO <b>Generalized Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Brain Syndrome</b> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Jan 1959</b>		20f. (City or town) <b>9/13/59</b> (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1959</b> to <b>9/13/59</b> , that I last saw the deceased alive on <b>7/11/59</b> and that death occurred at <b>1:55 PM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>1303 Frederick Road</b> DATE SIGNED <b>7/14/59</b>	
ACTUAL SIGNATURE <b>W.E. Mc Grath M. D.</b>		M.D. <b>1303 Frederick Avenue,</b>	
PHYSICIAN'S NAME (Type) <b>W.E. Mc Grath M. D.</b>		ADDRESS <b>1303 Frederick Avenue,</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/15/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Loring Byers</b>		24a. REC'D BY REGISTRAR <b>DATE JUL 21 '59</b>	
ADDRESS <b>8728 Liberty Road</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. K...</b>	
Randallstown, Md.			



7702

## CERTIFICATE OF DEATH

Reg. Dist. No.

07684

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>		c. LENGTH OF STAY IN 1b <b>X</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1908 Kernan Drive</b>		d. STREET ADDRESS <b>1908 Kernan Drive</b>	
3. NAME OF DECEASED (Type or print) <b>Dora A. Shipley</b>		4. DATE OF DEATH <b>July 18 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>6 - 22 - 1884</b>
9. AGE (In years last birthday) <b>75 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John King</b>		14. MOTHER'S MAIDEN NAME <b>Kate Sarbacker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>-----</b>	
17. INFORMANT <b>Edwin E. Shipley-1908 Kernan Drive</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinomatous</b> <b>151X</b> DUE TO (b) <b>Carcinoma of Stomach</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <b>6 months</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 18, 1959</b> to <b>July 18, 1959</b> that I last saw the deceased alive on <b>July 18, 1959</b> , and that death occurred at <b>11:45 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Danish Pelagosa MD</b>		ADDRESS (Street, city or town, state) <b>3326 Ardenwick Ave Baltimore 28 MD</b>	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 21-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. D. Wipperf</b>		ADDRESS <b>1300 Rutaw Place</b>	
24a. REC'D BY REGISTRAR <b>JUL 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Knapp</b>	

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7703 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07685

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto</b> <span style="float: right;">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md</b> <span style="float: right;">b. COUNTY <b>Balto</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balto rural</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balto rural</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				/d. STREET ADDRESS <b>303 Gumspring Rd Balto 6</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <div style="display: flex; justify-content: space-between;"><span>First <b>NANNIE</b></span><span>Middle <b>V.</b></span><span>Last <b>SIMS</b></span></div>				4. DATE OF DEATH <div style="display: flex; justify-content: space-between;"><span>Month <b>July</b></span><span>Day <b>8</b></span><span>Year <b>19 59</b></span></div>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5 Oct 1879</b>	
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John Norris</b>				14. MOTHER'S MAIDEN NAME <b>Susie Kennard</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <b>Helen Jenkins Winfield(niece) same</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Uremia</b> <b>4422</b> DUE TO <b>Renal Degeneration</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Atherosclerotic cardiavascular disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>unk</b> <b>unk</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Complete anorexia</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John C. Hyle MD</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John C Hyle MD</b>				DATE SIGNED <b>7-8-59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>7-13-59</b>		<b>Arbutus Mem. Park</b>		<b>Balto. Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Matthew A. Hensley</b>				ADDRESS <b>578 W. Biddle St</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 15 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles E. Hume</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Page 1, 2, and 3 to the funeral director. Give Page 4 to the funeral director. Give Page 5 to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7704

Item # 244 11/10/59 cap

## CERTIFICATE OF DEATH

Reg. Dist. No.

07586

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>CARROLL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ETTA</b> Middle <b>SINDLER</b> Last <b>SINDLER</b>		4. DATE OF DEATH Month <b>7</b> Day <b>3</b> Year <b>1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-23-97</b>
9. AGE (In years lost, birthday) <b>61 6/10 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARY LAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FRANKLIN BOBLITZ</b>		14. MOTHER'S MAIDEN NAME <b>MARY ALVAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>213-36-822</b>	
17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE LUNG</b> DUE TO (b) <b>CARCINOMA OF THE KIDNEYS</b> DUE TO (c) <b>- LIVER, PANCREAS + LYMPH NODES</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>LOP PULMONALE</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5-28</b> , 19 <b>59</b> , to <b>7-3-59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7-3</b> , 19 <b>59</b> , and that death occurred at <b>11:55 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William Newcomer</b> M.D.		ADDRESS (Street, city or town, state) <b>Mt. Wilson, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>		Superintendent	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JULY-7-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>GRAVE RUN</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE COUNTY, MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. COOK-TOWSON, INC. TOWSON 4 MD</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. K...</b>	





7705

## CERTIFICATE OF DEATH

Reg. Dist. No. 07687

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WOODLAWN</b>		c. LENGTH OF STAY IN TB <b>19 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>106 LOCUST DRIVE</b>		d. STREET ADDRESS <b>106 LOCUST DRIVE</b>	
3. NAME OF DECEASED (Type or print) <b>BERTHA ELIZ-GREFFEN-SKIPPER</b>		4. DATE OF DEATH <b>JULY 13 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 25, 1900</b>
9. AGE (In years last birthday) <b>58 yrs.</b>		IF UNDER 1 YEAR: Months <b>5</b> Days <b>13</b>	IF UNDER 24 HRS: Hours <b>13</b> Min. <b>1959</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at Home</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Henry Greffen</b>	
14. MOTHER'S MAIDEN NAME <b>Elma Ames</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>	
16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Milton Warren Skipper</b> Address <b>106 Locust Drive</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Crown Thrombosis</b> (b) <b>Cardio Vascular Disease &amp;</b> (c) <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>11/13/59</b> <b>1945</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month <b>11</b> Day <b>11</b> Year <b>1959</b> Hour <b>11</b> a. m. <b>11</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>3432 Frederick Ave</b>	20f. (City or town) <b>Baltimore</b> (County) <b>MD</b> (State) <b>MD</b>
21. I certify that I attended the deceased from <b>5/8</b> 19 <b>59</b> , that I last saw the deceased alive on <b>11/11</b> 19 <b>59</b> , and that death occurred at <b>1:00 PM</b> on <b>7/13</b> 19 <b>59</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Eliot W. Johnson</b>		DATE SIGNED <b>7/13/59</b>	
PHYSICIAN'S NAME (Type) <b>E. W. JOHNSON</b>		<b>Baltimore 29. Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 16 - 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cmn</b>	22d. LOCATION (City, town, or county) <b>Balto</b> (State) <b>Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John P. Kempf</b> ADDRESS <b>5311 Edmondson Ave</b>		24a. REC'D BY REGISTRAR <b>14 59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneiss</b>

TO HOSPITAL - ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7706

## CERTIFICATE OF DEATH

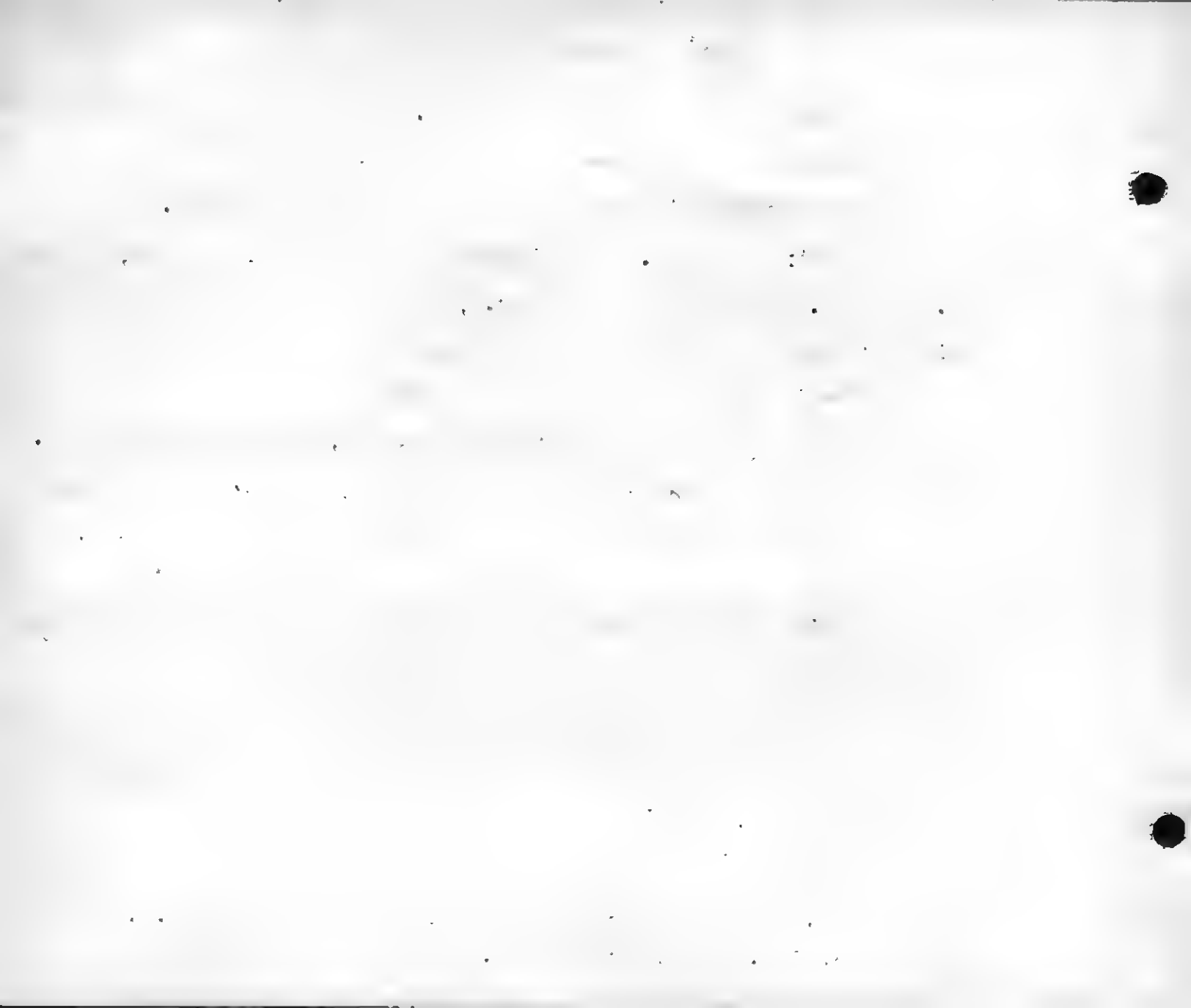
17588

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Ma.</b> b. COUNTY <b>10</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5510 Windsor Mill Rd</b>		e. STREET ADDRESS <b>5510 Windsor Mill Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>W.</b> Last <b>Slator</b>		4. DATE OF DEATH Month <b>July</b> Day <b>24</b> Year <b>19 59</b>	
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 5, 1881</b>
9. AGE (In years last birthday) <b>77</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Rancher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own</b>	
11. BIRTHPLACE (State or foreign country) <b>England</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Albert</b>		14. MOTHER'S MAIDEN NAME <b>Harriet</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
INFORMANT		Address <b>Mr William Flohr, 5510 Windsor Mill Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 CONGESTIVE HEART FAILURE</b> DUE TO (b) <b>ARTERIOSCLEROTIC HEART</b> DUE TO (c) <b>DISEASE + COR PULMONALE</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b> <b>3 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COND T ON G VEN IN PART I (a) <b>CHRONIC ASTHMATIC BRONCHITIS + EMPHYSEMA</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>JUNE 14, 1957</b> to <b>JULY 17, 1959</b> , that I last saw the deceased alive on <b>JULY 17, 1959</b> , and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Carlton L. Sexton</b>		ADDRESS (Street, city or town, state) <b>July 24, 1959</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>CARLTON L. SEXTON</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>Jul. 24/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Williston N.D.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Dir. 4101 Edmondson Ave.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 28 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7707

## CERTIFICATE OF DEATH

07689

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1009 Ingleside Avenue</b>		d. STREET ADDRESS <b>1009 Ingleside Avenue #28</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>ELBERTA</b> Middle <b>MARIE</b> Last <b>SMITH</b>		4. DATE OF DEATH Month <b>July</b> Day <b>18</b> Year <b>19 59</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 15, 1893</b>	
9. AGE (In years lost birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months <b>66</b> Days <b>18</b> Hours <b>19</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>John Oliver Brown</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Flynn</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		
17. INFORMANT <b>Mrs. Marie Reid-5480 Addington Road</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO <b>Coronary Atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 years</b> <b>15 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of Rt Breast &amp; Metastasis</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County)		(State)
21. I certify that I attended the deceased from <b>8/19, 1955</b> to <b>7-18, 1959</b> , that I last saw the deceased alive on <b>7-14, 1959</b> , and that death occurred at <b>3 A. M.</b> from the causes and on the date stated above.				
ACTUAL SIGNATURE <b>John Ashman</b>		M.D. <b>5907 Huguenot Club Ave 7-18-59</b>		
PHYSICIAN'S NAME (Type) <b>Balti. Md</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Entombment</b>		22b. DATE THEREOF <b>7/22/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Lorraine Park Cemetery</b>
22d. LOCATION (City, town, or county) <b>Woodlawn, Maryland</b>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tichner Home</b>		ADDRESS <b>Balti-17, Md.</b>		24a. REC'D BY REGISTRAR <b>JUL 21 '59</b>
24b. REGISTRAR'S SIGNATURE <b>Carlton S. Kraus</b>		DATE		

2000 10-10-00 10-10-00 10-10-00 10-10-00

7708

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Baltimore Co</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At home</u>		d. STREET ADDRESS <u>10 Pierpet ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>Fannie J Smith</u>		4. DATE OF DEATH Month <u>7</u> Day <u>13</u> Year <u>1959</u>	
5 SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/20/1862</u>
9. AGE (in years last birthday) <u>96</u> yrs		IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11 BIRTHPLACE (State or foreign country) <u>Ind</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>John Danner</u>		14 MOTHER'S MAIDEN NAME <u>Triombe Pole</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16 SOCIAL SECURITY NO <u>INFORMANT</u>	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>Cardio Vascular Disease (Senile)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>7/13/59</u> <u>18 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10/19</u> 19 <u>48</u> to <u>7/13</u> 19 <u>59</u> that I last saw the deceased alive on <u>7/2</u> 19 <u>59</u> , and that death occurred at <u>6:00 AM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Eliot W. Johnson</u>		ADDRESS (Street, city or town, state) <u>3432 Francis Ave</u>	
PHYSICIAN'S NAME (Type) <u>ELIOT W. JOHNSON MD. Baltimore 29 Md</u>		DATE SIGNED <u>7/14/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>7/15/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>McKenzie</u>	22d. LOCATION (City, town, or county) (State) <u>Howard Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mac Pratt &amp; Son</u>		ADDRESS <u></u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles L. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7709

## CERTIFICATE OF DEATH

Reg. Dist. No.

07691

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>Pasco</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4 Mico.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Newport Richy 48x</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>573 Edmundson Ave. (Ridgeway Manor N/H)</u>		d. STREET ADDRESS <u>#502 Warren Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Frederick</u> Middle <u>Harvey</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>July</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7 Sept. 1886</u>
9. AGE (In years last birthday) <u>72</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Civil Service</u>	
11. BIRTHPLACE (State or foreign country) <u>Endfield, Connecticut</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Smith</u>		14. MOTHER'S MAIDEN NAME <u>Margaret (Unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>1450 Norma A. Smith</u>		Address <u>520 Forest View Rd. Linthicum, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Generalized Atrial CV Dis</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/20</u> , 19 <u>59</u> to <u>7/23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7/23</u> , 19 <u>59</u> and that death occurred at <u>4:29</u> P. M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>429 S. Chester St. Balto 31 Md.</u>	
ACTUAL SIGNATURE <u>Theodore T. Nizirik M.D.</u>		DATE SIGNED <u>7/24/59</u>	
PHYSICIAN'S NAME (Type) <u>Theo. T. Nizirik M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>27 July 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. J. Sington</u>		ADDRESS <u>6100 Borne, Md.</u>	
24a. REC'D BY REGISTRAR <u>JUL 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles L. Hume</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7710

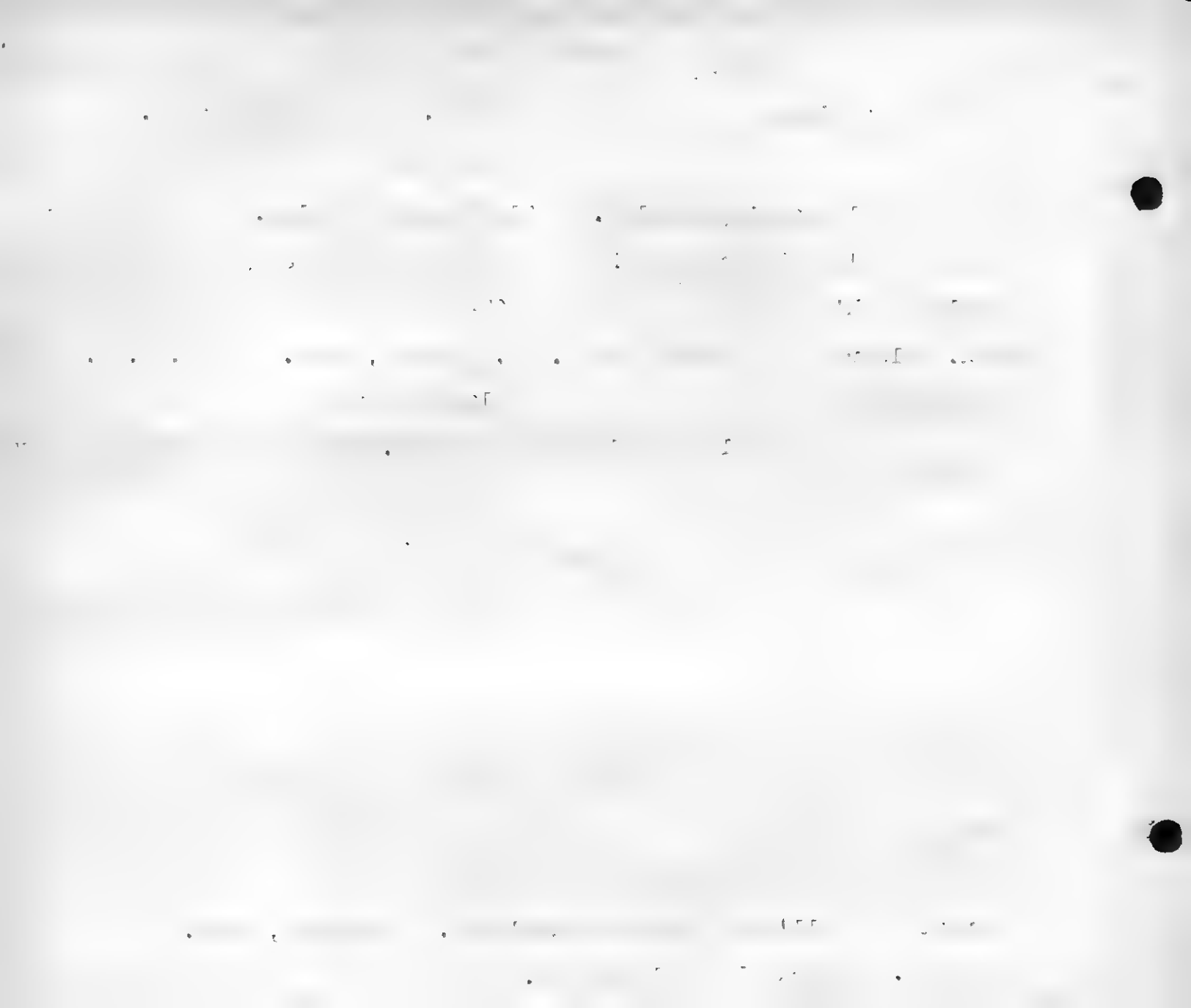
## CERTIFICATE OF DEATH

Reg. Dist. No. 07692

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before adm'ssion) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4714 Washington Blvd.</b>		d. STREET ADDRESS <b>4714 Washington Blvd.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Glen Clifford Smith</b>		4. DATE OF DEATH Month Day Year <b>July 7 19 59</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-27-08</b>
9. AGE (In years last birthday) yrs. <b>50</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mech. Welder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Empire Const. Co. Everett, Penn.</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Harry Smith</b>		14. MOTHER'S MAIDEN NAME <b>Blanche Heaty</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>170-12-3136</b>	
17. INFORMANT <b>Frances Eliz. Smith</b>		Address <b>4714 Washington Blvd</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>B. B. Brown</b> DUE TO <b>Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial Infarction</b> DUE TO (c)		<b>5 min</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)
21. I certify that I attended the deceased from <b>4/12/59</b> to <b>July 7, 1959</b> , that I last saw the deceased alive on <b>July 7, 1959</b> , and that death occurred at <b>11:35 PM</b> from the causes and on the date stated above.		
ADDRESS (Street, city or town, state)		DATE SIGNED
ACTUAL SIGNATURE <b>B. B. Brown</b> M.D.		<b>7/8/59</b>
PHYSICIAN'S NAME (Type) <b>B. B. Brown</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/11/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Shreve Chapel Cem.</b>
22d. LOCATION (City, town, or county) <b>Everett, Penn.</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		ADDRESS <b>4107 Wilkens Ave.</b>
24a. REC'D BY REGISTRAR DATE <b>JUL 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 7711 CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riderwood</b>		c. LENGTH OF STAY IN 1b <b>X Riderwood</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1422 W. Joppa Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>OLIVE</b> Middle <b>SEIPP</b> Last <b>SMITH</b>		4. DATE OF DEATH Month <b>July</b> Day <b>19</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 4, 1891</b>
9. AGE (in years last birthday) <b>67</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James A. Seipp</b>		14. MOTHER'S MAIDEN NAME <b>Annie Nook</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Family records</b>		Address	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arterio-sclerosis &amp; hypertension</b> DUE TO (c) <b>2042</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Sept 18, 1934</b> to <b>July 19, 1959</b> , that I last saw the deceased alive on <b>July 19, 1959</b> , and that death occurred at <b>5:05 P.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>1725 Rensselaers Rd. Pikesville 8 Md.</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Richard R. Williams</b> M.D.		PHYSICIAN'S NAME (Type) <b>Pikesville 8 Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 22, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Towson, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Maryland</b>		24a. REC'D BY REGISTRAR <b>DATE JUL 22 '59</b>	24b. REGISTRAR'S SIGNATURE <b>C. T. S. Hume</b>

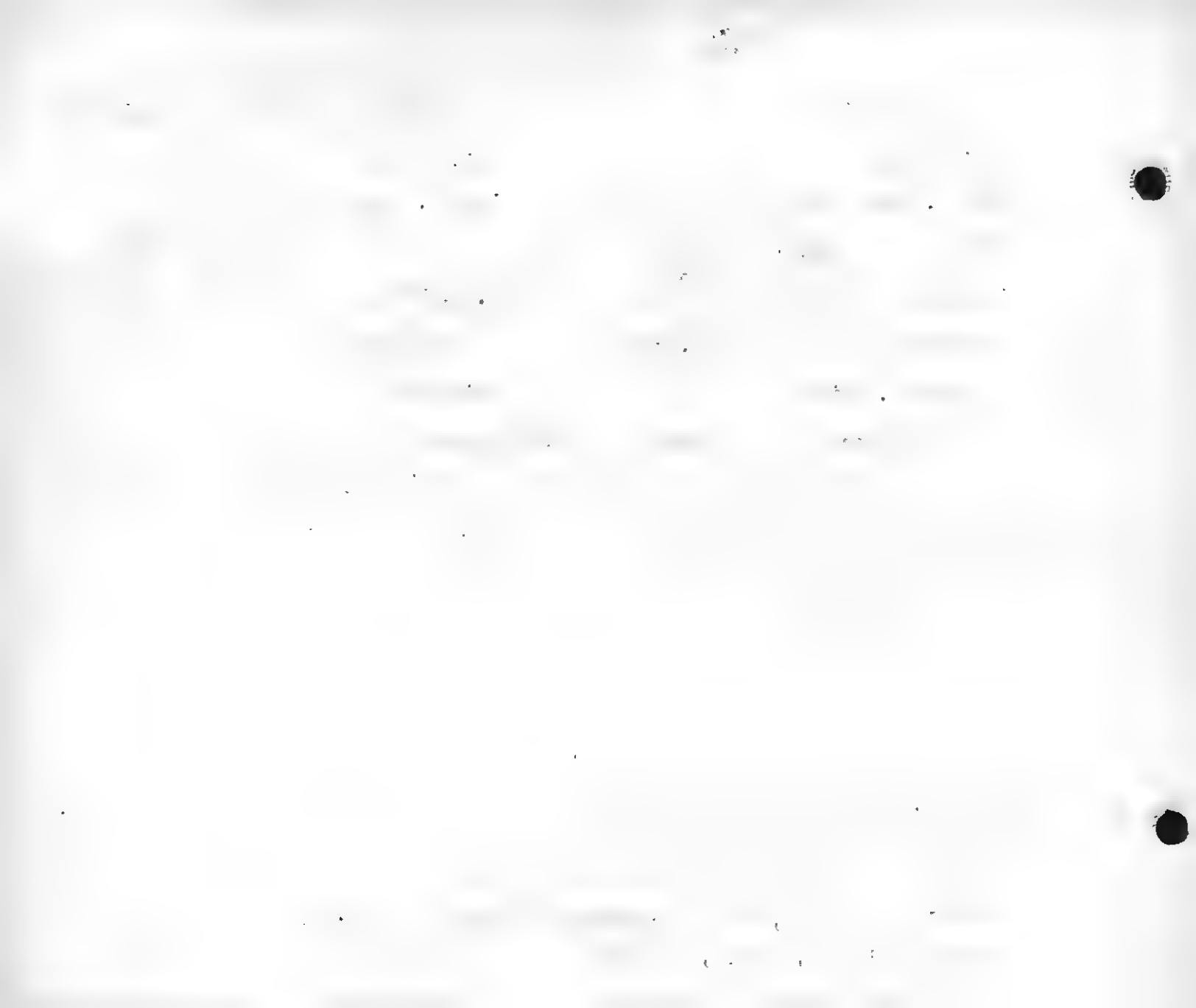
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

SALARY STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7712

CERTIFICATE OF DEATH

07694

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3 wks.		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Nursing Home		d. STREET ADDRESS 300 Marydell Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) William A. Smith		First Middle Last		4. DATE OF DEATH July 21, 1959		Month Day Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 25, 1888		9. AGE (In years last birthday) 71 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Own Shop		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Wallace Smith		14. MOTHER'S MAIDEN NAME Unknown							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO *****		17. INFORMANT Address A- Mabel E. Smith--300 Marydell Road					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 4 1.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 MINUTE 4 YEARS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from JAN. 20, 1956, to JULY 21, 1959, that I last saw the deceased alive on JULY 21, 1959, and that death occurred at 6:18 P.M. from the causes and on the date stated above.		ACTUAL SIGNATURE John F. Schaefer		M.D. 401 RANDOM ROAD BALTO. 29 MD.		ADDRESS (Street, city or town, state)		DATE SIGNED 7/23/59	
22a. BURIAL CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF July 24/59		22c. NAME OF CEMETERY OR CREMATORY Loudon Crematory		22d. LOCATION (City, town, or county) Baltimore Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. B. Shippert		ADDRESS 1300 Eutaw Place		24a. REC'D BY REGISTRAR DATE JUL 24 59		24b. REGISTRAR'S SIGNATURE J. B. Shippert			





7713

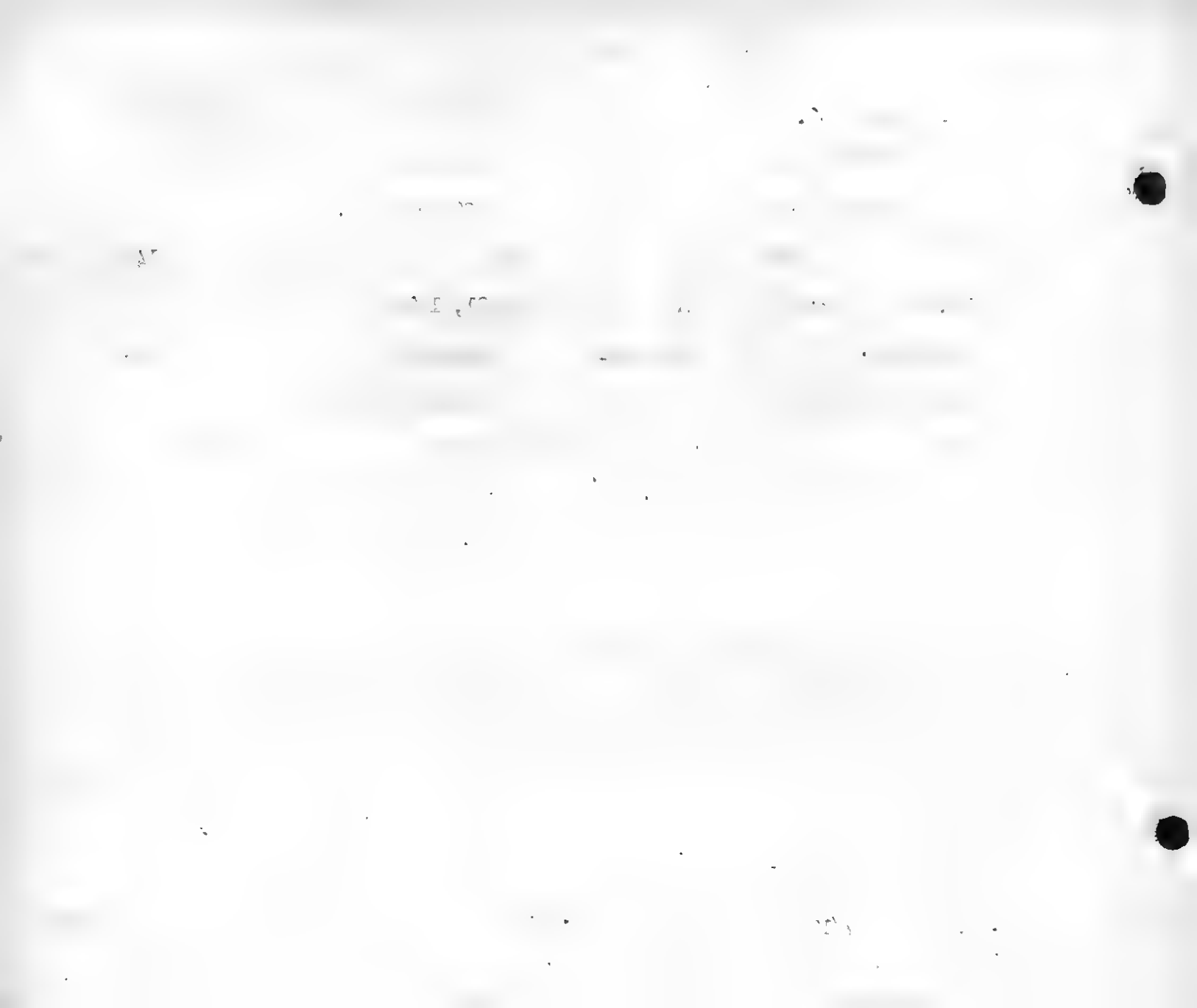
CERTIFICATE OF DEATH

Reg. Dist. No.

07695

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE CO.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and nearest town) <b>PIKESVILLE</b>		c. LENGTH OF STAY IN 1b <b>55</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>AUGSBURG HOME</b>		d. STREET ADDRESS <b>230 BURKE AVE.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b>		Middle <b>SOHN</b>		Last <b>(SOHN)</b>	
4. DATE OF DEATH Month <b>JULY</b>		Day <b>14</b>		Year <b>19 59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 21, 1873</b>		9. AGE (In years last birthday) yrs <b>86</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>FRANK HUTTON</b>		14. MOTHER'S MAIDEN NAME <b>KATE MEISER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		INFORMANT <b>CONRAD SOHN</b>	
Address <b>TOWSON</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260X</b> DUE TO <b>Diabetes mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio-sclerotic Heart Disease</b> DUE TO <b>Gangrene of Rt. Foot (3rd)</b> (c) <b>Generalized Arterio-sclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b> <b>5 yrs.</b> <b>2 months</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <b>July 1, 1959</b> , to <b>July 14, 1959</b> , that I last saw the deceased alive on <b>July 12, 1959</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Earl L. Chambers</b>		M.D. <b>4108 Liberty St. C. Balto.</b>		DATE SIGNED <b>7-17-59</b>	
PHYSICIAN'S NAME (Type) <b>DR. EARL L. CHAMBERS.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7/17/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD CEMETERY</b>	
22d. LOCATION (City, town, or county) <b>PARKVILLE</b>		(State) <b>MARYLAND</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 22 '59</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns Sais</b>		ADDRESS <b>Towson, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Kneass</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7714

CERTIFICATE OF DEATH

Reg. Dist. No.

07696

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>At home</b>		d. STREET ADDRESS <b>508 Anneslie Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM CLEMENT SPRING</b>		4. DATE OF DEATH Month Day Year <b>7/6/59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 1902</b>
9. AGE (In years last birthday) yrs. <b>56</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Publicity agent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>self</b>	
11. BIRTHPLACE (State or foreign country) <b>New Hampshire</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Arthur W. Spring</b>		14. MOTHER'S MAIDEN NAME <b>Ann Finn</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Catheryne Spring</b>		Address <b>508 Anneslie Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cirrhosis of Liver</b> <b>081.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 1951</b> to <b>July 3, 1959</b> , that I last saw the deceased alive on <b>July 2, 1959</b> , and that death occurred at <b>4<sup>th</sup> fl.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7501 York Rd. Balto. Co.</b> DATE SIGNED <b>7/8/59</b>			
ACTUAL SIGNATURE <b>Charles F. O'Donnell M.D.</b>			
PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>7/6/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Mem.</b>	22d. LOCATION (City, town, or county) (State) <b>Balto. Co.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>WIEDEFELD &amp; SON</b>		ADDRESS <b>GREENMOUNT AVE &amp; 22ND</b>	24a. REC'D BY REGISTRAR DATE <b>JUL 8 59</b>
		24b. REGISTRAR'S SIGNATURE <b>Charles E. Frank</b>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7715

## CERTIFICATE OF DEATH

07697

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>44 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SAMUEL</b> Middle <b>L.</b> Last <b>STOLTZ</b>		4. DATE OF DEATH Month <b>July</b> Day <b>6</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 15, 1894</b>
9. AGE (In years last birthday) yrs. <b>65</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cemetery</b>	
11. BIRTHPLACE (State or foreign country) <b>Lithuania</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>Israel Stoltz</b>		14. MOTHER'S MAIDEN NAME <b>Anna Freeman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO <b>048-05-5854</b>	
17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMA, RIGHT MAXILLARY ANTRUM WITH METASTASIS</b> 160.2 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 23</b> 19 <b>59</b> , to <b>July 6</b> 19 <b>59</b> , and that death occurred at <b>6:00 AM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>John W. Crawford</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b> <b>7/6/59</b>			
ACTUAL SIGNATURE <b>John W. Crawford</b>		PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b> <b>VAH, FORT HOWARD, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>7-6-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>B'Nai Israel Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hartford, Connecticut</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc.</b> <b>Baltimore 14, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 9 '59</b>	
24b. REGISTRAR'S SIGNATURE <i>Conrad L. Hines</i>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

7551

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07698

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7308 SCHOOL AVE</u>				e. STREET ADDRESS <u>7308 SCHOOL AVE</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE</u> <u>STRAUSS</u>				4. DATE OF DEATH Month Day Year <u>JULY</u> <u>12</u> <u>19 59</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 26, 1889</u>	9. AGE (In years last birthday) <u>70</u> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		
13. FATHER'S NAME <u>CHRISTIAN STRAUSS</u>			14. MOTHER'S MAIDEN NAME <u>ANNA M. AULL</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>YES</u> <u>WW I</u>			16. SOCIAL SECURITY NO. <u>717-07-7654</u>		17. INFORMANT Address <u>MRS PERTHA KELLER 7307 MARTELL</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (b) <u>A-S-C-U DISEASE</u> (a), stating the underlying cause last DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>None</u>				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		
20f. (City or town) <u>DUNDALK</u>			20g. (County) <u>BALTIMORE</u>		20h. (State) <u>MARYLAND</u>		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>M. B. Davis</u>			M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>M. B. DAVIS MD</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			22b. DATE THEREOF <u>7/15/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MORELAND PARK</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>ULLRICH FUNERAL HOME-DUNDALK MD</u>			ADDRESS <u>DUNDALK MD</u>		24a. REC'D BY REGISTRAR <u>Coling &amp; Anna</u>		
					24b. REGISTRAR'S SIGNATURE <u>7/13/59</u>		

DATE SIGNED





TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7716

## CERTIFICATE OF DEATH

07699

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admitt on) a. STATE <u>MD</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto. 7</u>	c. LENGTH OF STAY IN 1b <u>1 week</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick 1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>his daughter's home</u> <u>3411 Fairview Ave Balto 7</u>		e. STREET ADDRESS <u>R.F.D 7, Frederick, Md</u>	
3. NAME OF DECEASED (Type or print) <u>Charles B. Streett</u>		4. DATE OF DEATH Month <u>July</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> <u>NEVER MARRIED</u> <u>WIDOWER</u>	8. DATE OF BIRTH <u>Dec 28, 1880</u>
9. AGE (in years last birthday) <u>78</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done, or no most of working life, even if retired) <u>Retired Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Painting</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Streett</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Blaine</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) <u>?</u>		16. SOCIAL SECURITY NO <u>?</u>	
17. INFORMANT <u>Mrs. Blanche A. Streett</u>		Address <u>RFD 7, Frederick, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma Prostate</u> <u>177X</u> DUE TO <u>With metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arteriosclerosis &amp; Metastases</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>59</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 19, 1959</u> to <u>July 25, 1959</u> that I last saw the deceased alive on <u>July 25, 1959</u> , and that death occurred at <u>4:46</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>P.O. Box 3033W, Baltimore</u> DATE SIGNED <u>July 30, 1959</u>			
ACTUAL SIGNATURE <u>M. Paul Byers</u> M.D.		PHYSICIAN'S NAME (Type) <u>M. Paul Byers</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/28/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Loring Byers</u>		24a. REC'D BY REGISTRAR <u>Jul 30 '59</u>	
ADDRESS <u>8738 Fidelity Rd. Randallstown, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

100



7717

## CERTIFICATE OF DEATH

Reg. Dist. No.

07700

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in the Pines-16 Fusting Ave.</u>				d. STREET ADDRESS <u>4 Upland Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LAURA</u> Middle <u>A.</u> Last <u>SUMMERS</u>				4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 30, 1875</u>	
9. AGE (In years lost birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Samuel Burrows</u>				14. MOTHER'S MAIDEN NAME <u>Martha -</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. E. Mae Maser - 4 Upland Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Discompensation</u>							
DUE TO (b) <u>Chs. Hypertensive Cardio Vascular Diseases</u>							
DUE TO (c) <u>10 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>3-29, 1959</u> , to <u>7-7, 1959</u> , that I last saw the deceased alive on <u>7-7-1959</u> , and that death occurred at <u>12:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u>				M.D. <u>6209 Frederick Ave.</u> DATE SIGNED <u>7-7-59</u>			
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>				<u>Baltimore-28, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/10/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>London Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. 29, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wilmer K. Gallagher</u>				ADDRESS <u>17</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 13 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7718

# CERTIFICATE OF DEATH

07701

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOUSE IN THE PINES</u>		e. STREET ADDRESS <u>614 LONGVIEW RD.</u>	
3. NAME OF DECEASED (Type or print) <u>GEORGE ASHTON SUTHERLAND SR.</u>		4. DATE OF DEATH <u>JULY 12, 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 4, 1854</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR: Months <u>12</u> Days <u>12</u> Hours <u>19</u> Min <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>1ST NAT. BANK</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>GEORGE A. SUTHERLAND</u>		14. MOTHER'S MAIDEN NAME <u>SUSAN BAKER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-14-1171</u>	
17. INFORMANT <u>MR. ROBERT B. SUTHERLAND</u> Address <u>614 LONGVIEW DR.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>450.0 RT SIDED CARDIAC FAILURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO (c) <u>myocardial infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>14 July 1959</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/23, 1958</u> , to <u>6/12, 1959</u> , that I last saw the deceased alive on <u>6/11, 1959</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Cliff Ratliff, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>4605 Edmore Ave</u> DATE SIGNED <u>July 14 '59</u>	
PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF JR.</u>		<u>Ball 29, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JULY 13, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>WILLIAM FUNERAL DIR. 4101 EDMONDSON AVE.</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 14 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			









# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7720

## CERTIFICATE OF DEATH

07704

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>23yr5mth8dys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D. C.</b> <b>47x-2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>1029 Monroe Street - N. E.</b>			
3. NAME OF DECEASED (Type or print) First <b>Herbert</b> Middle <b>Taylor</b> Last <b>Taylor</b>				4. DATE OF DEATH Month <b>July</b> Day <b>23</b> Year <b>19 59</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 18, 1895</b>	
9. AGE (In years last birthday) <b>63</b> yrs		IF UNDER 1 YEAR Months <b>63</b> Days <b>00</b> Hours <b>00</b> Min <b>00</b>		IF UNDER 24 HRS Months <b>00</b> Days <b>00</b> Hours <b>00</b> Min <b>00</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>W. S. Taylor</b>				14. MOTHER'S MAIDEN NAME <b>Maryl Olndorff</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Unknown</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Records; SPRING GROVE STATE HOSPITAL</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lymphosarcomatosis, generalized</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>00.1</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 10</b> , 19 <b>59</b> to <b>July 23</b> , 19 <b>59</b> that I last saw the deceased alive on <b>July 23</b> , 19 <b>59</b> , and that death occurred at <b>8:40 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stella Wachslar</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 7-23-59</b>			
PRINTED NAME (Type) <b>Stella Wachslar, M. D.</b>				<b>Catonsville 28, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City town, or county) (State)	
<b>Burial</b>		<b>7-25-59</b>		<b>St. Elizabeth's</b>		<b>Wash. D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. G. Mattingly</b>				ADDRESS <b>131-11th St. S.E.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 27 59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 7721 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dwings Mills</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Froyleigh Convalescent Home</u>		e. STREET ADDRESS <u>Dolefield Road</u>	
3. NAME OF DECEASED (Type or print) <u>BENJAMIN</u> First <u>STUART</u> Middle <u>TONGUE</u> Last		4. DATE OF DEATH <u>July</u> Month <u>13</u> Day <u>1959</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 27, 1896</u>
9. AGE (in years last birthday) <u>62</u> yrs		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>13</u> Hours <u>13</u> Min	11. IF UNDER 24 HRS Months <u>6</u> Days <u>13</u> Hours <u>13</u> Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Broker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas T. Tongue</u>		14. MOTHER'S MAIDEN NAME <u>Mary Van Ardale</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO <u>WWI</u>	
17. INFORMANT <u>Mrs Margaret Dodd Tongue</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>7 pharynx</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <u>July 13, 1959</u> Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 1954, to <u>July 13</u> , 1959, that I last saw the deceased alive on <u>July 13</u> , 1959, and that death occurred at <u>6:15 P.M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>6 E. Eager St. Balto.</u> DATE SIGNED <u>7/15/59</u>			
ACTUAL SIGNATURE <u>Dr. Warde B. Allan</u> M.D. <u>6 E. Eager St. Balto.</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Warde B. Allan</u> , 6 E. Eager St., Baltimore 2, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>July 15, 1959</u>	<u>Druid Ridge Cemetery</u>	<u>Pikesville, Balto., Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
<u>Sherry W. Jenkins &amp; Sons Co.</u>		<u>DATE JUL 15 '59</u>	
ADDRESS <u>4905 York Road</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Hines</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7722

## CERTIFICATE OF DEATH

07706

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PIKESVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PIKESVILLE</b>	
c. LENGTH OF STAY IN 1b <b>8 yrs</b>		d. STREET ADDRESS <b>17 HAWTHORNE AVE.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>17 HAWTHORNE AVE.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>NORMAN SAMUEL VALENTINE</b>		4. DATE OF DEATH <b>7-26-1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT 29-1902</b>
9. AGE (In years last birthday) <b>56</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRACTOR TRAILER OPER. JAMES GIBBONS DETOUR MARYLAND</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S.A.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HARVEY EDGAR VALENTINE</b>		14. MOTHER'S MAIDEN NAME <b>ADIE B. TROXELL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or in service) <b>NO</b>		16. SOCIAL SECURITY NO <b>213-016-310</b>	
17. ADDRESS <b>Mrs. ADELINE M. VALENTINE, 17 Hawthorne</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>103.8</b> DUE TO <b>Carcinoma of Colon with Metastasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>2 yrs</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March</b> , 1957, to <b>JULY 26</b> , 1959, that I lost saw the deceased alive on <b>JULY 23</b> , 1959, and that death occurred at <b>4:00 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James G. Miller</b>		ADDRESS (Street, city or town, state) <b>1331 Reisterstown Rd., Pikesville, Md.</b>	
PHYSICIAN'S NAME (Type) <b>James G. Miller</b>		DATE SIGNED <b>7/27/59</b>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify)	22b. DATE THEREOF <b>7-29-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>EVERGREEN MEMORIAL</b>	22d. LOCATION (City, town, or county) (State) <b>Finksburg, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank H. Russell - Pikesville, Maryland</b>		24a. REC'D BY REGISTRAR <b>JUL 29 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Calvin S. Hume</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7723 CERTIFICATE OF DEATH

Reg. Dist. No.

07707

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>3yr5mth16dys</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pisgah, Maryland</u>		d. STREET ADDRESS <u>08X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>M.</u> Last <u>Vanderslice</u>		4. DATE OF DEATH Month <u>July</u> Day <u>11</u> Year <u>1959</u>	
5 SEX <u>female</u>	6 COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 15, 1879</u>
9. AGE (In years last birthday) <u>80</u> yrs		IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>19</u> Min <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Vanderslice</u>		14. MOTHER'S MAIDEN NAME <u>Cecelia Mattie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO <u>Unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Decompensatory heartdisease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive heart failure</u> DUE TO (c) <u>Arteriosclerotic cardiovascular disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>months</u> <u>years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. <u>19</u> Month, Day, Year p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 6, 1959</u> , to <u>7-11-1959</u> , that I last saw the deceased alive on <u>July 11, 1959</u> , and that death occurred at <u>1035 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>SPRING GROVE STATE HOSPITAL</u> <u>7-12-59</u>			
ACTUAL SIGNATURE <u>Alexisopoulos</u>		M.D. <u>SPRING GROVE STATE HOSPITAL</u>	
PHYSICIAN'S NAME (Type) <u>ARISTIDES M. SIMOPOULOS</u> <u>Catonsville 28, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>15 JULY 59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Wash DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Funeral Home</u>		ADDRESS <u>44 Manassas NE</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 14 59</u>		24b. REGISTRAR'S SIGNATURE <u>Curtis S. Harris</u>	





# BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7724 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **07708**

FOR STATE  
HEALTH DEPT.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b <u>instant</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa, Rural, R.D. # 1 Box 336</u> d. STREET ADDRESS <u>Clayton Rd.,</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Paul</u> Middle <u>Sylvester</u> Last <u>Vanorsdale</u>				<b>4. DATE OF DEATH</b> Month <u>July</u> Day <u>19</u> Year <u>1959</u>					
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Dec. 3, 1929</u>		<b>9. AGE</b> (In years last birthday) <u>29</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS: Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Home Repairs</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Akron, Ohio</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.,</u>	
<b>13. FATHER'S NAME</b> <u>Elmer Vanorsdale</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Wisner</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service) <u>yes</u> <u>Korean</u>		<b>16. SOCIAL SECURITY NO.</b> <u>236-42-2331</u>		<b>17. INFORMANT</b> <u>Mary L. Vanorsdale, Joppa, Maryland.</u>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fractured Neck - Crushing</u> <u>823X</u> DUE TO (b) <u>Injury to Chest Probable</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Fractured Skull</u> Sudden								INTERVAL BETWEEN ONSET AND DEATH _____	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Brought to mobile which struck Steel Utility Pole</u> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) _____ 20c. TIME OF INJURY Month, Day, Year <u>7/19/1959</u> Hour <u>4</u> m. <u>am</u> 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>State Road</u> 20f. (City or town) <u>Towson</u> (County) <u>Balto.</u> (State) <u>Maryland</u>									
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
<b>ACTUAL SIGNATURE</b> <u>Charles F. O'Donnell</u> (M.D.) <b>EXAMINER'S NAME</b> (Type) <u>Charles F. O'Donnell</u>						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>7/21/1959</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Bel Air Memorial Gardens</u>		<b>22d. LOCATION</b> (City, town, or county) <u>Bel Air</u> (State) <u>Md.</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Edward R. McCombs Jr</u>				<b>ADDRESS</b> <u>Abingdon, Md.,</u>		<b>24a. REC'D BY REGISTRAR</b> <u>DATE JUL 23 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Knead</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-inhumation permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



7725

## CERTIFICATE OF DEATH

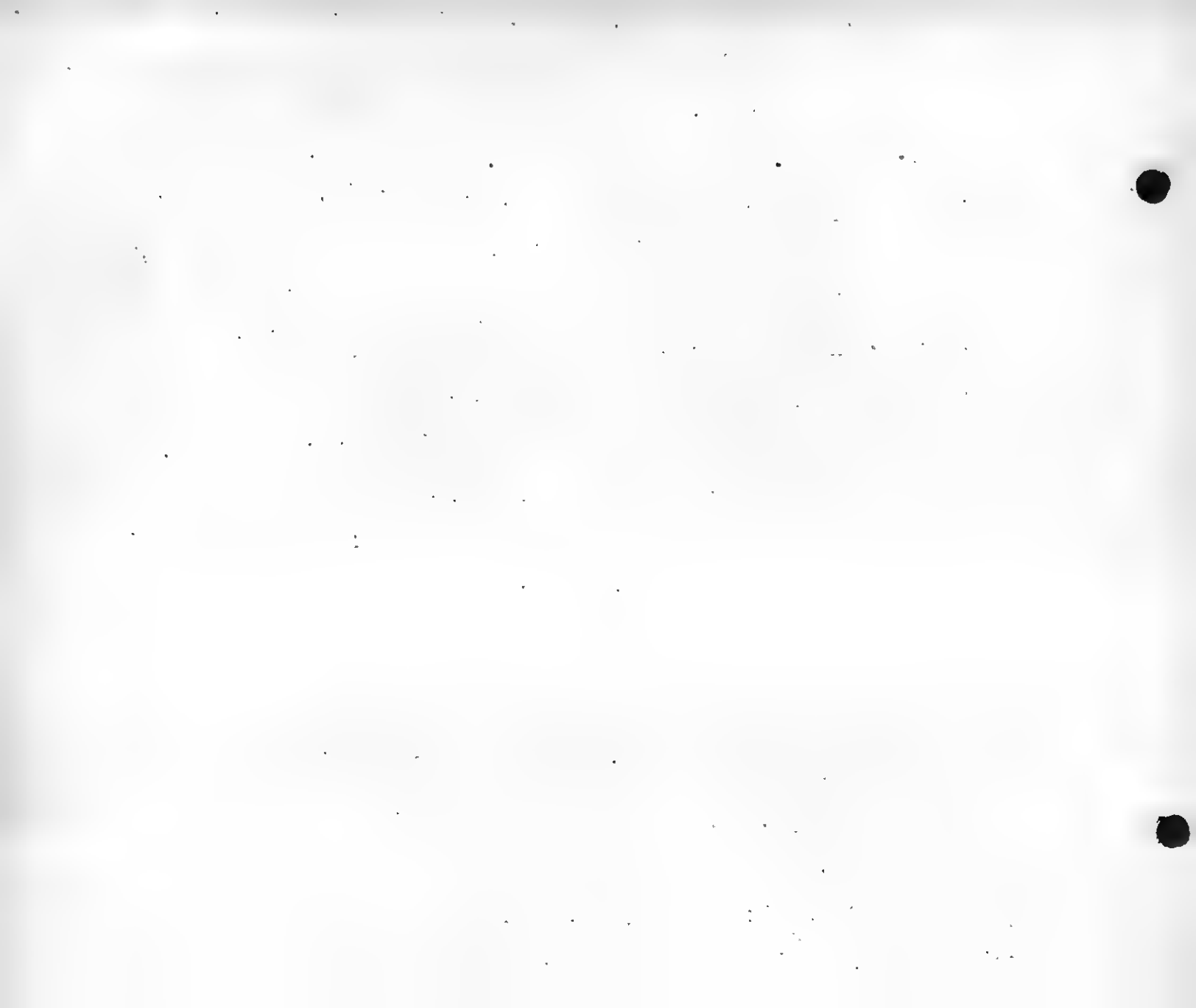
Reg. Dist. No.

07709

1. PLACE OF DEATH o COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>Md</u> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2505 Lightfoot Drive</u>		d. STREET ADDRESS <u>2505 Lightfoot Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Oscar</u> First <u>Wasserman</u> Middle <u>Wasserman</u> Last		4. DATE OF DEATH Month <u>7</u> Day <u>8</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS Hours _____ Min _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>meat</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Morris Wasserman</u>	
14. MOTHER'S MAIDEN NAME <u>Bessie</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____	
16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>Anne Wasserman</u> Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension and Hypertension Cardio-vascular disease.</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Thrombosis of Basilar artery and</u> DUE TO <u>Stroke. (Cerebro-vascular accident)</u> (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>years.</u> <u>3 months.</u> <u>2 days.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>April 2</u> , 19 <u>59</u> , to <u>July 8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 8</u> , 19 <u>59</u> , and that death occurred at <u>7:50 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4215 Park Heights Ave. #15</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>A. Gelpira</u> M.D. PHYSICIAN'S NAME (Type) <u>Dr. A. GOLPIRA</u> <u>July 8th, 1959</u>			
22a. BURIAL, CREMATION, REMOVA. (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCAT. (City, town, or county) (State)
<u>Burial</u>	<u>7-9-59</u>	<u>Rosedale</u>	<u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u> ADDRESS <u>2100 Eutan Pl</u>		24a. REC'D BY REGISTRAR <u>DAHL 10'59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knecht</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7726

## CERTIFICATE OF DEATH

Reg Dist. No. 07710

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Carney</b>				c. LENGTH OF STAY IN 1b <b>4 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3407 Orbital Road</b>				d. STREET ADDRESS <b>3407 Orbital Road</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Anna L Webb</b>				4. DATE OF DEATH Month Day Year <b>July 18 / 59 19</b>			
5 SEX <b>female</b>		6 COLOR OR RACE <b>white</b>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov 9 1900</b>	
9. AGE (In years last birthday) <b>58</b> yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>Frederick J Eckert</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Felter</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>No.</b>				16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Mrs Kathryn Cuomo 3939 Lyndale Ave</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarction</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic heart disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>5 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July 6</b> , 1959, to <b>July 15</b> , 1959, that I last saw the deceased alive on <b>July 18</b> , 1959, and that death occurred at <b>3</b> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3601 Greenway Baltimore</b> DATE SIGNED <b>20 39</b>							
ACTUAL SIGNATURE <b>Stephen J Van Dill Jr</b> M.D.				PHYSICIAN'S NAME (Type) <b>3601 Greenway Baltimore</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>July 22/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Co Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home 4210 Belair Road.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 22 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove the urban papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 7727 CERTIFICATE OF DEATH

07711

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>6 S. Beechwood Ave.</i>		e. STREET ADDRESS <i>16 S. Beechwood Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>Robert James Webb</i> First Middle Last		4. DATE OF DEATH Month <i>7</i> Day <i>1</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/9/73</i>
9. AGE (In years last birthday) <i>85</i> yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>U.S. mail</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Carrier</i>	11. BIRTHPLACE (State or foreign country) <i>Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Philip Webb</i>	
14. MOTHER'S MAIDEN NAME <i>Powell</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>Edith Webb</i>		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter on y one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> DUE TO <i>Cardio-Vascular Disease &amp; General</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterio-sclerosis marked</i> DUE TO (c) <i>Arterio-sclerosis marked</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>1957</i>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>11/10</i> , 19 <i>49</i> , to <i>7/1</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>6/30</i> , 19 <i>59</i> , and that death occurred at <i>2:05 PM</i> , from the causes and on the date stated above			
ACTUAL SIGNATURE <i>Eliot W. Johnson</i> M.D.		ADDRESS (Street, city or town, state) <i>3432 Oceanview Ave</i> DATE SIGNED <i>7/1/59</i>	
PHYSICIAN'S NAME (Type) <i>Robert James Webb</i>		22a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	
22b. DATE THEREOF <i>7/4/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn</i>	
22d. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>		24a. REC'D BY REGISTRAR <i>Jul 6 '59</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mac Webb &amp; Son</i> ADDRESS <i>28</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hume</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





7728

## CERTIFICATE OF DEATH

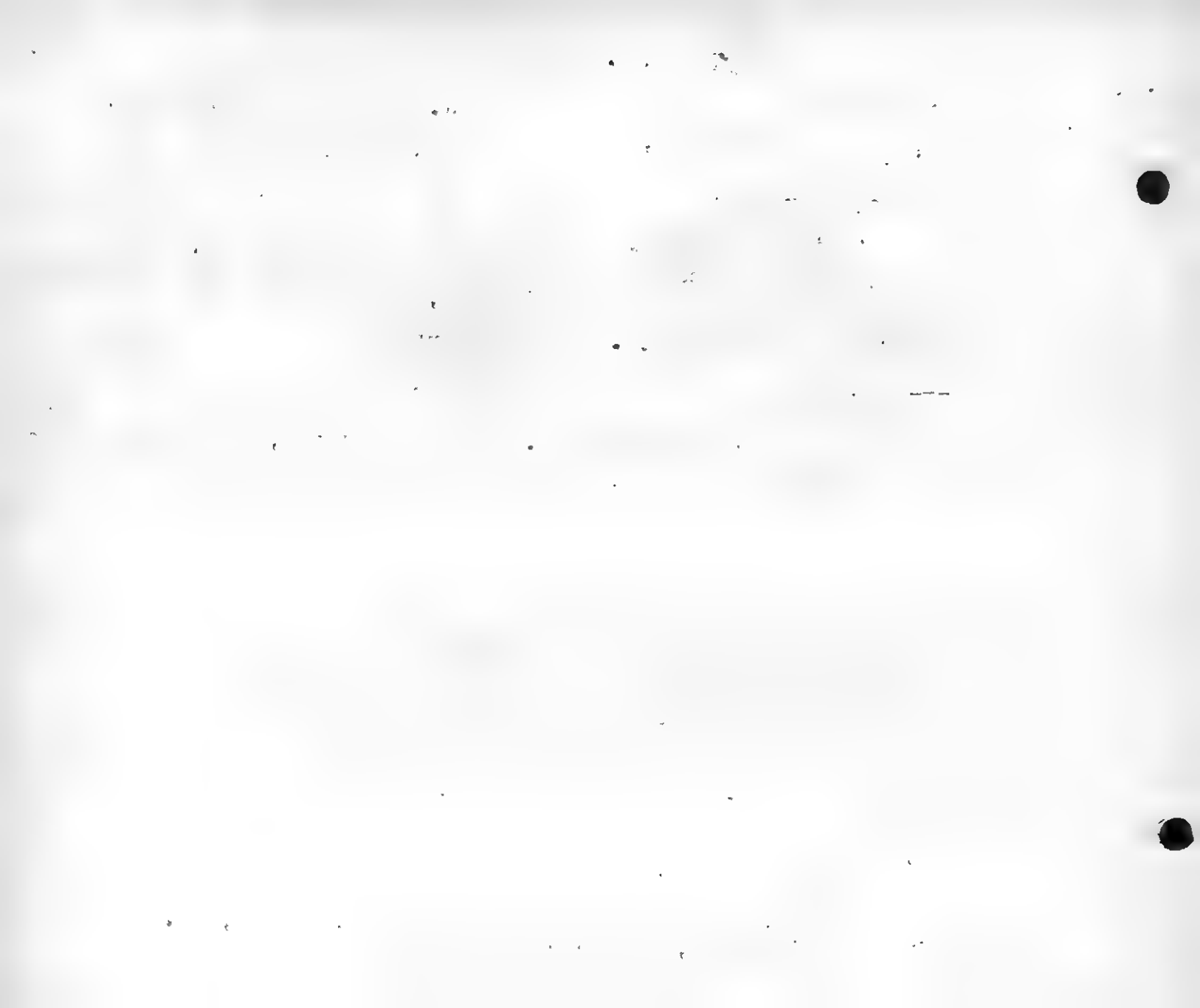
Reg. Dist. No.

07712

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o STATE <b>Md.</b> b COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>9 yrs</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>1917 Rolling Glen Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Alois Weimer</b> First Middle Last		4. DATE OF DEATH <b>July 16/59</b> Month Day Year	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 5, 1889</b>
9. AGE (In years lost birthday) <b>70</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Weimer Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>---Weimer</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>217 32 8542</b>	
17. INFORMANT <b>Mrs. Margarite Weimer, 1917 Rolling Glen Road</b>			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarction, acute</b>			
DUE TO <b>440.1</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 16, 1959</b> to <b>July 16, 1959</b> , that I last saw the deceased alive on <b>July 16, 1959</b> , and that death occurred at <b>4:00 PM</b> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Theodore T. Nizewski M.D.</b>			
PHYSICIAN'S NAME (Type) <b>Theodore T. Nizewski M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 20/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore 7, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Nitzke Funeral Directors, 4101 Edmondson Ave.</b>		24. REGISTRAR'S SIGNATURE <b>Charles E. Hume</b>	
DATE <b>JUL 21 '59</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7729

## CERTIFICATE OF DEATH

Reg. Dist. No.

07713

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 12		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1301 Glendale Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harold</u> Middle <u>David</u> Last <u>Welsh</u>		4. DATE OF DEATH Month <u>7-</u> Day <u>13-</u> Year <u>1959</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 11, 1895</u>
9 AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>03</u> Days <u>03</u>	IF UNDER 24 HRS Hours <u>03</u> Min <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gas &amp; Elec. Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry Welsh</u> <u>Welch</u>		14. MOTHER'S MAIDEN NAME <u>Nellie Mac Intire</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Helen Welsh 1301 Glendale Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO <u>GENERALIZED ARTERIOSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>&gt; 15 yrs.</u> DUE TO (c) <u>DIABETES MELLITUS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November</u> , 1958, to <u>July</u> , 1959, that I last saw the deceased alive on <u>July 13</u> , 1959, and that death occurred at <u>11:55 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Albert B. Bradley</u> M.D.		ADDRESS (Street, city or town, state) <u>4900 Belair Rd. Balto. 6, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Albert B. Bradley</u>		DATE SIGNED <u>7/14/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-17-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road</u>		24a. REC'D BY REGISTRAR <u>JUL 16 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur E. Fenn</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY CLERK: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form IM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7730 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07714

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Providence Road</u>		d. STREET ADDRESS <u>Providence Road</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>WERNIK</u> Last <u>WERNIK</u>		4. DATE OF DEATH Month <u>July</u> Day <u>18</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 22, 1876</u>
9. AGE (In years, months, and days) <u>82</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	11. BIRTHPLACE (State or foreign country) <u>Poland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Frances Karwacki</u>		Address <u>3625 Echodale Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC Heart Disease</u> DUE TO (b) <u>400.00</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> o. m. <u></u> p. m. <u></u> Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>R. S. Fisher</u>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R. S. FISHER</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <u>7-19-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/22/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. F. SADOWSKI &amp; SONS, 1808 EASTERN AVE</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 22 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7731 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07715

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO.</b>			
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>OWINGS MILLS</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OWINGS MILLS</b>			
c. LENGTH OF STAY IN 1b <b>18 YRS 5 MO</b>				d. STREET ADDRESS <b>ROSEWOOD STATE TRAINING SCHOOL</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LAMAR</b> Middle <b>WIGGER</b> Last <b>WIGGER</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>28</b> Year <b>1959</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOV. 26, 1933</b>	
9. AGE (In years and birthday) <b>25</b> yrs.		IF UNDER 1 YEAR Months <b>28</b> Days <b>28</b> Hours <b>19</b> Min.		IF UNDER 24 HRS. Months <b>28</b> Days <b>28</b> Hours <b>19</b> Min.		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>WILLIAM HENRY WIGGER</b>				14. MOTHER'S MAIDEN NAME <b>CARMELA ROSE BROCATO</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>ROSEWOOD RECORDS</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>STRANGULATION</b> <b>795.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>MASSIVE ASPIRATION OF STOMACH CONTENTS</b> DUE TO (c) <b>10 MIN.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>NONE</b>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>NONE</b>			
20c. TIME OF INJURY Hour <b>NONE</b> m. <b>NONE</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>NONE</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Martin E. Strobel</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Martin E. Strobel</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 31/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rosewood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Owings Mills Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F.Eline &amp; Sons Reisterstown, Md.</b>				24a. REC'D BY REGISTRAR <b>BUL 31 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





7732

CERTIFICATE OF DEATH

Reg. Dist. No.

07716

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>		c. LENGTH OF STAY IN 1b <b>4 MONTHS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARY BEAVER WOLFE</b>		4. DATE OF DEATH Month Day Year <b>JULY 29 1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/24/1877</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>WILLIAM BEAVER</b>		14. MOTHER'S MAIDEN NAME <b>SUSAN HALL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Frank L. Smith Jr.</b>		Address <b>Cockeysville</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Arterio Sclerotic Cardio Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio Sclerotic Cardio Vascular Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>4/1</b> , 1959, to <b>7/29</b> , 1959, that I last saw the deceased alive on <b>7/24</b> , 1959, and that death occurred at <b>7:28 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cockeysville, Md</b> DATE SIGNED <b>7/29/59</b>			
ACTUAL SIGNATURE <b>Walter T. Kees</b>		M.D. <b>Cockeysville, Md</b>	
PHYSICIAN'S NAME (Type) <b>Walter T. Kees</b>		<b>Cockeysville, Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>8-1-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Woodland, Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 31 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7733

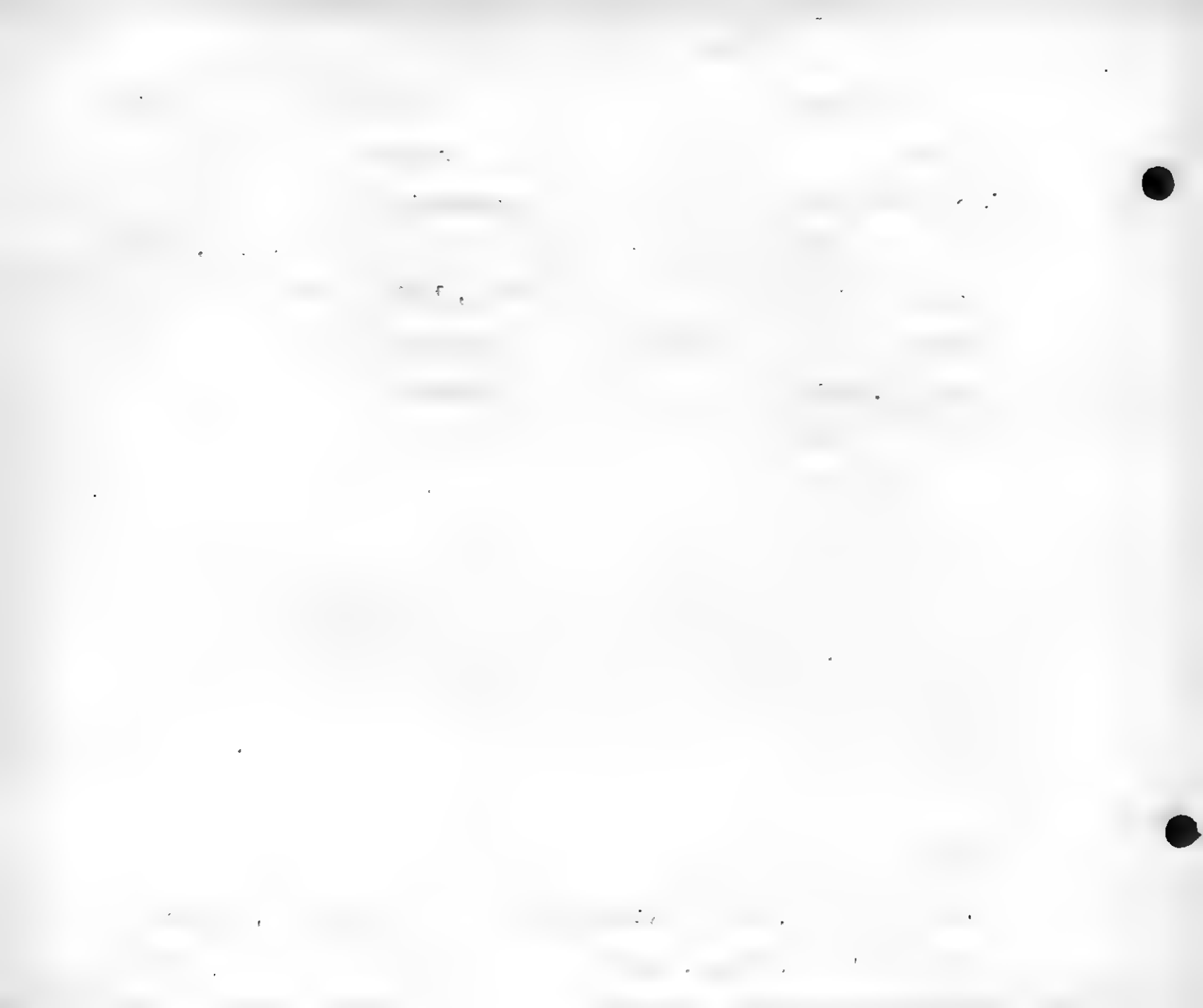
## CERTIFICATE OF DEATH

07717

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sunnybrook</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Codd Nursing Home</b>		d. STREET ADDRESS <b>Jarrettsville Pike</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>HELEN ALICE WOOD</b>		4. DATE OF DEATH Month Day Year <b>July 6, 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>June 7, 1903</b>
9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Robert M. Ruhl</b>	
14. MOTHER'S MAIDEN NAME <b>Annie Lee</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>Family records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>IX</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebrovascular Accident</b> (c) <b>Arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 1/4 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 13, 1958</b> , to <b>July 7, 1959</b> , that I last saw the deceased alive on <b>June 30, 1959</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>1014 St Paul St, Balt 2, Md.</b>			
ACTUAL SIGNATURE <b>J. Frank Supplee, Jr.</b>		M.D. <b>1014 St Paul St, Balt 2, Md.</b>	
PHYSICIAN'S NAME (Type) <b>J. Frank Supplee, Jr.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 10, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Sunnybrook, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 13 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 of this certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

7552

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07718

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>720 S. 51st Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>YINGLING</b> Last		4. DATE OF DEATH Month <b>July</b> Day <b>30</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 8, 1885</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Albert E. Glaser</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Popp</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>George H. Yingling</b>		Address <b>720 S. 51st Street-22</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atherosclerotic Heart Disease</b> 400.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Atherosclerosis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>59 yrs.</b> <b>20 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Ullrich</b>		DATE SIGNED <b>7-30 59</b>	
EXAMINER'S NAME (Type) <b>Sack &amp; Collins</b>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Aug. 1, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home Dundalk, Md.</b>		24a. REC'D BY REGISTRAR <b>Aug 3 '59</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7734 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07719

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u> c. LENGTH OF STAY IN TB <u>15 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montrose Ave.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u> d. STREET ADDRESS <u>Montrose Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First <u>YAKIM</u> Middle <u>YOCKOWCKE</u> Last <u>YOCKOWCKE</u>				<b>4. DATE OF DEATH</b> July <u>17</u> 19 <u>59</u>									
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>About 1899</u>		<b>9. AGE</b> (In years last birthday) <u>59</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Gardening</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Lawnmower</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Poland</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>UNKNOWN</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>UNKNOWN</u>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service) <u>NO</u>				<b>16. SOCIAL SECURITY NO.</b> <u>219-15-6382</u>		<b>17. INFORMANT</b> Address <u>William D. Brown, 107 Delight Rd. Owings Mills.</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr.</u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>													
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b> <u>none</u>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>									
<b>20c. TIME OF INJURY</b> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>none</u>		<b>20f. (City or town)</b> <u>none</u>		<b>(County)</b> <u>  </u>		<b>(State)</b> <u>  </u>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>													
<b>ACTUAL SIGNATURE</b> <u>D. D. Caples</u>						<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			<b>DATE SIGNED</b> <u>7-20-59</u>				
<b>EXAMINER'S NAME (Type)</b> <u>D. D. Caples, M. D.</u>						<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>7-20-59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Druid Ridge</u>				<b>22d. LOCATION (City, town, or county)</b> <u>Pikesville, Md.</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Frank H. Jewell, Pikesville, Md.</u>						<b>24a. REC'D BY REGISTRAR</b> DATE <u>JUL 22 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hines</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7735 CERTIFICATE OF DEATH

Reg. Dist. No.

07720

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>26 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>300 S. Pulaski Street (23)</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED Known: <b>WESLEY</b> First Middle <b>ZIDWICK</b> Last ad: <b>WESLEY</b> <b>ZIDKOWICK</b> (Type or print)		4. DATE OF DEATH Month <b>July</b> Day <b>7</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 15, 1895</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Proprietor - Unemployed Grocery store</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Russia</b>	9. AGE (In years last birthday) yrs. <b>64</b> IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Dimitri Zidkoviak</b>		14. MOTHER'S MAIDEN NAME <b>Sophia Zankovitz</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give year or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>216-32-9259</b>	
17. INFORMANT <b>Glin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS UNDERLYING IMMEDIATE CAUSE (a) <b>BRONCHOGENIC CARCINOMA, RIGHT LUNG, WITH</b> <b>162.1</b> <b>GENERALIZED METASTASES</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>DUE TO</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROTIC HEART DISEASE - 10 YEARS</b> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Hour o. m. Month, Day, Year <b>19</b> 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I attended the deceased from <b>June 11</b> , 19 <b>59</b> , to <b>July 7</b> , 19 <b>59</b> , and that death occurred at <b>11:15 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>John W. Crawford</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b> <b>7/8/59</b> PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b> <b>VAH, FORT HOWARD, MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/13/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Cowan &amp; Sons</b>		24a. REC'D BY REGISTRAR <b>Hollins &amp; Poppleton</b> <b>Baltimore, Md.</b> DATE <b>JUL 10 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Carlton S. Hume</b>			

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Physician	
10. Signature of Registrar		11. Date of Registration		12. Office of Registrar	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# 1 7736 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

07721

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Foxleigh Nursing Home</u>				d. STREET ADDRESS <u>Marriottsville Rd. Box 368</u>			
3. NAME OF DECEASED (Type or print) First <u>RUSSELL</u> Middle <u>C.</u> Last <u>ZIMMERMAN</u>				4. DATE OF DEATH Month <u>July</u> Day <u>31</u> Year <u>19 59</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 9, 1906</u>	9. AGE (In years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder - self employed</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Zimmerman</u>				14. MOTHER'S MAIDEN NAME <u>Blanche Mays</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mrs. Mary Thelma Zimmerman - Marriottsville Rd.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thromboses</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO <u>Diabetes Mellitus</u> (c) <u>Diabetes Mellitus</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>10 yrs.</u> <u>20 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Sept. 1946</u> to <u>July 31, 1959</u> , that I last saw the deceased alive on <u>July 30, 1959</u> , and that death occurred at <u>11 A.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Herbert Goldstone</u>				M.D. <u>1810 FULTON PLACE</u>			
PHYSICIAN'S NAME (Type) <u>HERBERT GOLDSTONE M.D.</u>				<u>BALTIMORE MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/4/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John L. Dickner</u>				ADDRESS <u>1700</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 3 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kraus</u>			

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Physician	
10. Signature of Registrar		11. Signature of Coroner		12. Signature of Medical Examiner	
13. Signature of Burial Officer		14. Signature of Undertaker		15. Signature of Funeral Home	
16. Signature of Cemetery		17. Signature of Burial Site		18. Signature of Interment	
19. Signature of Burial Site		20. Signature of Interment		21. Signature of Burial Site	
22. Signature of Interment		23. Signature of Burial Site		24. Signature of Interment	
25. Signature of Burial Site		26. Signature of Interment		27. Signature of Burial Site	
28. Signature of Interment		29. Signature of Burial Site		30. Signature of Interment	
31. Signature of Burial Site		32. Signature of Interment		33. Signature of Burial Site	
34. Signature of Interment		35. Signature of Burial Site		36. Signature of Interment	
37. Signature of Burial Site		38. Signature of Interment		39. Signature of Burial Site	
40. Signature of Interment		41. Signature of Burial Site		42. Signature of Interment	
43. Signature of Burial Site		44. Signature of Interment		45. Signature of Burial Site	
46. Signature of Interment		47. Signature of Burial Site		48. Signature of Interment	
49. Signature of Burial Site		50. Signature of Interment		51. Signature of Burial Site	
52. Signature of Interment		53. Signature of Burial Site		54. Signature of Interment	
55. Signature of Burial Site		56. Signature of Interment		57. Signature of Burial Site	
58. Signature of Interment		59. Signature of Burial Site		60. Signature of Interment	
61. Signature of Burial Site		62. Signature of Interment		63. Signature of Burial Site	
64. Signature of Interment		65. Signature of Burial Site		66. Signature of Interment	
67. Signature of Burial Site		68. Signature of Interment		69. Signature of Burial Site	
70. Signature of Interment		71. Signature of Burial Site		72. Signature of Interment	
73. Signature of Burial Site		74. Signature of Interment		75. Signature of Burial Site	
76. Signature of Interment		77. Signature of Burial Site		78. Signature of Interment	
79. Signature of Burial Site		80. Signature of Interment		81. Signature of Burial Site	
82. Signature of Interment		83. Signature of Burial Site		84. Signature of Interment	
85. Signature of Burial Site		86. Signature of Interment		87. Signature of Burial Site	
88. Signature of Interment		89. Signature of Burial Site		90. Signature of Interment	
91. Signature of Burial Site		92. Signature of Interment		93. Signature of Burial Site	
94. Signature of Interment		95. Signature of Burial Site		96. Signature of Interment	
97. Signature of Burial Site		98. Signature of Interment		99. Signature of Burial Site	
100. Signature of Interment		101. Signature of Burial Site		102. Signature of Interment	